

**SISTERHOOD IS CERVICAL: A SOCIOLOGY OF THE BODY, GENDER AND
HEALTH**

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ABSTRACT

Sisterhood is Cervical: A Sociology of the Body, Gender and Health

This thesis addresses the sociology of the body and of governance, by presenting empirical material, in the form of both textual and interview data, drawn from a case study of cervical screening. This material is used to examine women's experiences and their sense of embodiment in the context of cervical screening participation. The thesis argues that cervical screening, as a form of prevention, represents a new form of social regulation in late modernity. This argument challenges current understandings of the relationship between the body, gender and health. First, the thesis poses a distinction between the body and the concept of embodiment and argues that conflation of these two concepts obscures social processes and experiences. Second, the thesis addresses tensions between notions of citizenship and surveillance in literature which focuses on bodily regulation and issues of health. Third, the thesis reveals previously obscured aspects of this experience, such as risk, obligation, trust and entitlement.

I declare that this thesis has been composed by myself
and that the work is my own.

Acknowledgements

This work is not, of course my own - whilst I have collected original data and tried to redefine debate in relation to the sociology of the body, gender and health, I have done so through interaction and negotiation with many others. Tom McGlew and Kath Melia oversaw the early stages of the thesis and my colleagues in the Department of Sociology, at the University of Edinburgh, granted me the space to complete my thesis whilst in post. I have greatly appreciated their attempt to protect me from administrative burdens and their support to complete the task. I am grateful to those who have been my teachers and in particular to my supervisors, Sue Scott and John Holmwood. They have consistently provided intellectual insight and ideas which I have worried at and teased out in relation to my work, and my debt to them goes well beyond my references to their published work. My thanks are also due to Pauline Padfield, who provided endless methodological and epistemological discussion, and to Sue Mawdsley, who provided valuable support in the preparation of the final text. Finally, Richard and Holly Watt have been especially patient and loving in the final stages of preparing this thesis and have helped me keep body and soul intact. This work represents their support.

For Holly and her mother

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PROLOGUE

A Letter from the Doctor

Dear _

I see from our records that you are due to have your next cervical smear. I should be grateful if you would please telephone my receptionist to ask for a cervical smear test appointment. If you have had a cervical smear taken elsewhere could you please inform the surgery in order that your records can be updated.

Yours sincerely

Doctor _

A woman receives a letter from her health centre asking her to get in touch with the receptionist to make an appointment for a smear test. Information on the status of her cervix is held on computerised records: there is a pool of data on other cervixes of which her cervix forms part. Someone has scrutinised those records and identified that her cervix needs to be monitored. This information is passed onto the woman, in case she has forgotten. The language of the letter is perfunctory, polite, cajoling and formal. The onus is on the woman to make an appointment for her smear, an appointment in a special category of its own. The cervix occupies a unique place within general practice as a body part subject to regular assessment and scrutiny. Whilst there is acknowledgement in the letter that a woman may have a smear taken elsewhere, the onus is on her to feed this information to her doctor, so that she can be contacted the next time her smear is due. The letter does not suggest that to opt out altogether is, in any sense, an option.

Whilst not all women receive a letter from their general practitioner requesting that they make an appointment for a smear, at some stage in their life course, most women will be asked when they had their last smear, and offered a smear. *Reluctance* to participate is an initial response for some women:¹

¹ The quotations presented here are taken from interview data gathered as part of the thesis, which are presented in Section Three. Biographical details of the women participating in the study are in Appendix I.

'one day I got a letter asking me to go to the doctors to have a smear. And I thought, cheek, damn, I'm not going for no smear.' [Margaret]

'...when she suggested to me that I make an appointment to go back and have a smear done...I thought, I'm not going for that.' [Rose]

A range of responses are engendered by women who have different understandings about the purpose and implications of a cervical smear. For instance, some perceive it as a *routine procedure* for all women.

'[I thought] it was just part of a routine health procedure at the family planning clinic.' [Teresa]

'I went for my first smear and I really thought it was par for the course. You just knew you had to go and get a smear test and that was it.' [Ann]

'It was just one of those things, I just know that you've got to get it done. You know, you find out everything's OK.' [Eve]

Some women see it as an explicit means of *detecting* cancer:

'I thought they were checking you for something like they check to see if there's anything there. I knew it was related to cervical cancer.' [Ivy]

Or as a means of *preventing* cancer:

'I knew everything about it, I knew it was to prevent cervical cancer or if they had the ~~information~~ to catch it in time and clear it up.' [Carol]

'I knew it was to prevent any cancer or anything.' [Lorna]

Others view the cervical smear as part of a package of health *entitlements* and as a way of acquiring *information* about one's own body.

'I just took it as part of what you get.' [Fiona]

'I thought this was very necessary, this needs to get done.' [Linda]

'I had never had one before so I felt that it was quite good to have it done.' [Julie]

Despite the variety of initial responses to this request, invitation or injunction to have a smear, many women comply and either make an appointment to have a smear, or give permission for a smear to be taken at the time the request is made.

The Examination

'I was quite young at the time so I thought it was a bit traumatic...getting this instrument up inside you. But once it was over it was OK. Even although you've been married and have a kid it's still embarrassing...it's your dignity.' [Susan]

A woman who has a cervical smear taken, is asked to lie on her back in the examination room, bring her knees up to her chest, to keep her ankles together, and let her knees fall to either side of her body. Either a doctor or a practice nurse will take the smear according to local health board or authority established guidelines. A speculum, either steel or plastic, is inserted into the woman's vagina and opened out to push the walls of the vagina apart, and make the cervix visible. The doctor or nurse then observes the shape, contour and colour of the cervix.

Occasionally, it can be difficult to see. Once the cervix has been observed, the smear is taken, using a standard technique devised in the 1940s. This method scrapes cells from the surface of the cervix which are then spread onto a microscopic slide and 'fixed' for their journey to a laboratory. The cells are examined cytologically using a stain which distinguishes between different kinds of cells, and cells in different stages of development. The cells are then classified according to a variety of categories, devised by the British Society for Clinical Cytology.²

Waiting for the Results

'[The smear result arrived in] two or three weeks. It said it showed mild changes and could I please come back to have a second one in three months? I thought then, I don't really like this.' [Julie]

After the smear is taken and interpreted, a brief letter is normally sent to the woman from the laboratory, (although practices vary, and in some health boards and authorities, women must phone their general

² For details of the classification systems used see Appendix II.

practitioner in order to obtain their smear result). Women are informed about smears which are not classified as 'normal', which are described through a variety of expressions, such as 'pre-cancerous', 'suspicious', 'abnormal', 'mild changes' or 'positive'. Depending on the classification of the cervical cells, the woman may be asked to return for a repeat smear. If it is normal, she will be called for a repeat smear in three or five years' time, depending on local policy. If there are abnormal changes, repeat smears are taken in either three, six or twelve months, depending on the degree of abnormality. Alternatively, the woman is referred for colposcopy.

Colposcopic examination, usually an outpatient procedure, shows where the changed cells are and what they look like. A colposcope is a microscope which makes it easier for the doctor to see the cervix and cervical cells. The cervix is stained with fluid such as saline, acetic acid and sometimes iodine, to show up particular parts of the cervix. Sometimes a biopsy is taken from what appear to be the most affected areas and sent for histology. If this is the case, a local anaesthetic is often injected into the cervix. If pre-cancerous cells are detected, they may be treated by 'ablative therapy' or excision. The former includes laser; 'cold' coagulation; cryocautery; diathermy treatment and may be treated on an out-patient basis. Excision involves a variety of procedures such as diathermy loop excision, cone biopsy or more radically, hysterectomy.

Cervical screening has developed as a form of secondary prevention based on the identification of precancerous cells, which is typically represented as a simple, safe procedure with high levels of success. Despite the certainty in which these interventions appear to be framed, for many women, there is considerable ambiguity associated with the language and experience of screening. In contrast to the linear development of interventions detailed by policy and laboratory guidelines, women may have a more disruptive and truncated experience of screening. Whilst a majority of smears are classified as normal, many are classified in degrees of abnormality which may or may not progress to cancer or other forms of cervical disease. Abnormal smears may appear normal upon repeat smear, then regress to abnormal on the second repeat. The natural history of cervical cancer is itself unclear and non-linear, and abnormal

cells require further investigation, examination or treatment in ways which may intensify women's participation in a series of out and/or in-patient encounters.

The experience of further observation and/or treatment in the name of prevention can therefore be ambiguous and uncertain. The identification of cervical smears as detecting 'pre-cancerous' cells has potential for confusion both for women and for medical practitioners, as the latter increasingly acknowledge. Further examination through colposcopy may be perceived by some as treatment rather than examination. For many women, the experience of screening and the contact with a variety of actors and social negotiations which this may bring, may raise issues of risk and anxiety. There is considerable scope for ambiguity and diversity in the experience of cervical screening, despite its representation and rhetorical power as a simple form of secondary prevention. Indeed, cervical screening represents what has been termed the 'prevention paradox' (Rose, 1985), in the sense that whilst screening is measured as beneficial for populations, it may be troubling for individuals. Despite this, women who participate in cervical screening develop strategies to negotiate and transform the sense of risk and anxiety which may accompany this experience. Moreover, participation in screening is often accompanied by a strong sense of social obligation.

Sociology and the Cervix

This thesis arises from the observation that cervical screening exemplifies what Bryan S. Turner (1987) has termed the 'Foucault paradox'. In contemporary capitalist societies, where welfare systems provide a greater degree of equality of opportunity in relation to health care, and where health is increasingly perceived as a desirable, though limited resource, the state is required to provide a correspondingly greater degree of regulation over its populations. Citizenship is broadly considered as a series of individual rights and entitlements, therefore, the paradox is that the provision of citizenship, of which health is an aspect, entails greater surveillance and social regulation by quasi-governmental organisations and agencies.

In this regard, prevention has been identified as a new form of social regulation, in which new populations and new aspects of people's lives have increasingly come under state and other agencies of surveillance (Arney, 1982; Armstrong, 1983). This observation derives both from sociological analysis of the body and health and from sociological analysis of governance. The thesis addresses such analyses by presenting material, in the form of interview and textual data, drawn from a case study of cervical screening. This material is used to examine women's experiences of participation in cervical screening, their sense of embodiment in this process and sociological understandings of the relationship between the body, gender and health.

The thesis is presented in three sections. Section One reviews the status of the body in sociological thought, the relationship of this thought to categories of gender and health and the relevance of Foucault in this enterprise. Whilst Foucauldian frameworks have been used to identify the processes through which bodies are socially marked out for surveillance, they have failed to identify the embodied experience of surveillance. Indeed, the development of the sociology of the body has tended to conflate the body and embodiment in ways which, I shall argue, obscure social processes and experiences. Chapter One, therefore, addresses sociological debates on the body and surveillance and Chapter Two examines the contribution of feminism to understandings of embodiment. In conclusion of Section one, I present an emerging critique of the Foucauldian literature on the body, and, drawing upon feminist argument as a statement of gendered subjectivity, I pose a distinction between the body and embodiment.

Section Two outlines the substantive area of cervical screening and introduces the research which forms the core of the thesis. Chapter Three presents historical and documentary data from medical and other health-related journals which I use to examine the development of cervical screening as a modern medical project. These data suggest a shift in medical observation of the cervix, from diagnosis and detection to prevention. I examine discourses which underlie this shift and suggest that considerable implications for lay understandings of prevention are embedded within the unresolved epistemologies which underpin

screening. These epistemologies relate to issues of intersubjectivity in the interpretation of smears and raise questions about the nature and status of both expert and lay knowledge in the context of prevention.

Chapter Four introduces current approaches in social science to cervical screening, which have primarily focused on issues of lay knowledge, belief and attitude. This work has self-consciously contributed to the production of knowledge which is used to challenge and correct lay beliefs in the interests of securing participation in screening. In contrast, drawing on the concerns presented in Section One, I suggest an alternative approach, which addresses the ways in which women make sense of a 'routine' experience and what this reveals about the relationship between the body, gender and health.

This approach is developed in Section Three, in which I introduce empirical material in the form of interviews with women who have had different categories of smear tests, both normal and abnormal, and a range in between. I have used this data to examine the talk, stories and language which describe and detail experiences of screening. The material in Chapters Five and Six points to considerable diversity in women's interpretations of their screening experiences. In particular I have focused on the ways in which themes and accounts of obligation and entitlement, risk and trust are expressed, and I draw attention to the ways in which the experience of surveillance, within cervical screening, produces and intensifies understandings of risk and obligation. In Chapter Seven I present a methodological discussion as reflection on the creative process through which the thesis has been produced.

These different kinds of data inform the central arguments of the thesis in three main ways. First, they highlight the status of the body in sociological thought and point to a need for conceptual clarity between the body and embodiment. Second, they highlight tensions between citizenship and surveillance as they are negotiated and managed by women in the context of cervical screening participation. Third, a concern with embodiment reveals previously obscured aspects of experience, which have implications for sociological reflection on the body, gender and health.

SECTION ONE

This section reviews sociological thought which has addressed the body and draws attention to both the relevance of Foucault and feminism in this enterprise. In Chapter One I trace sociological interest in the body, and suggest that the emergence of a (re)new(ed) focus on the body is fundamental to the development of sociology as a discipline. It is not that the 'body' has been added to other sub-areas of the discipline, but that the idea of the discipline, and the language of 'discipline', has been transformed through an address to the body. I will, therefore, outline analytical frameworks through which the body and embodied experience have been developed and highlight the sources of sociological influence on this thesis. Among these frameworks, that of Foucault and his emphasis upon a new regime of bodily regulation is the most distinctive. In particular, I draw on key studies which focus on medical practices and aspects of prevention which exemplify the processes and practices of surveillance.

In Chapter Two I introduce feminist discussion of embodied experience relating to issues of health. Feminist theory has been crucial to the development of a sociology of the body, through arguments around gender differentiation, power and knowledge and the challenges posed to the 'givenness' of the body both across historical time and culture. Of particular importance for feminist theory, discussions of female embodied experience draw attention to the ungendered nature of Foucauldian arguments. However, the notion of embodied experience itself implies a universal and static position and further, occupies an ambiguous status in feminist analysis. In Chapter Two, therefore, I challenge this ambiguity through the concept of embodiment and revisit the significance of Foucault for understandings of the body, gender and health, by presenting an emerging critique of the use of surveillance in the sociology of the body. I argue that whilst this work has been valuable in developing a Foucauldian framework with which to identify the *processes* through which bodies are socially marked out for surveillance, the diversity of *experiences* of, and resistances to, these processes are obscured.

CHAPTER ONE
THE SOCIOLOGY OF THE BODY
Locating the Body in Sociology

Sociological Theory and the Body

The body in sociology is now a 'phenomenon considered worthy of detailed study in its own right in the late twentieth century' (Shilling, 1993, p29). Indeed, the editorial of the first issue of *Body and Society* is emphatic that it is no longer the case that the body is ignored within sociology (Featherstone and Turner, 1995). However, it is commonly agreed that sociology has responded to, and created, a new interest in the body in ways which have been theoretically driven. Sociological interest in the body has centred on tensions between the development of theoretical frameworks with which to put the body into the project of general theory and the (re)introduction of embodied agency to the sociological project (Turner, 1984; Bury, 1995).

The body has been identified as an 'absent presence' within sociology, in the sense that the body has been acknowledged as integral to agency, but has not formed part of the extended conceptual treatment of human action and interaction. For instance, Turner has focused much of his work on reclaiming general theory for the body, whilst at the same time, drawing attention to the way in which this work has reproduced the Cartesian legacy of Western systems of thought, in which mind and body are viewed as discrete. Turner has consistently argued that the human body has not formed an explicit part of the development of sociological theory (see for instance, Turner, 1984; 1987; 1991; 1992).

One of the principal ways in which the body has been conceptualised within sociological theory is as an organic entity, which forms a stable condition of social action (Turner, 1992). Assuming the body's biological stability provides it with a determining status, onto which social categories are superimposed. The body in sociological theory is perceived as external to the actor, as a constraint, or as a condition of action which may, at times, be understood as a source of opposition to instrumental reason. Within sociological theory then, the body has historically been positioned outside the social, or as pre-social, as entering into social

action, and as constituent of it, but not itself constituted through social action.

Turner's work must largely be seen as a critique of Cartesian dualism, in which mind and body have been perceived as separate entities. As he argues, sociology has developed as a science of action and interaction, where 'action' reproduces this dualism between mind and body. Indeed, Cartesianism can be seen as a false 'bourgeois' dichotomy in which subject/object; organism/environment; mind/body are analytically separate (Freund, 1988).¹ Furthermore, sociology's disciplinary acceptance of a biological frame of reference in which to locate the body is not unusual. The history of Western thought has developed through a progressive embodiment of the self (Elias, 1978), in which the body, as an discrete entity, has been used to make a significant distinction between self and other, thus bracketing out the body as a condition but not as a constituent of action.

The critique of sociology mounted by Turner, and those who follow him, draws attention to the way in which Cartesianism has informed the project of general theory. Others have pointed out that the development of a disembodied sociology has itself been a response to biological reductionism, in order to establish intellectual autonomy (Freund, 1988). Nevertheless, despite debate about the degree to which Cartesian dualism has been the paradigm in which sociology has operated, Turner gives himself the task of integrating notions of embodied agency into the contemporary sociological project. For instance, he seeks to reclaim Weber's work on agency for the sociology of the body, and recent attempts by other sociologists have developed these claims (see for instance, Hughes, 1995).

In similar fashion, Turner points to the work of Parsons and draws attention to the implicit forms in which the body is present in his version

¹ Other commentators, however, have argued that this dualism was never as sharp as theoreticians such as Turner suggest. Bury (1995) for instance, vigorously denies this version of Cartesianism and suggests that theorists such as Nietzsche and Popper operated with much more blurred notions of the relationship between mind, body and also emotion (Freund, 1990).

of structural-functionalism. In his hierarchy of social life, Parsons (1966) positions the organism as the lowest and most stable aspect of social relations. The body, indeed, is seen as an action system, or as 'an integrative sub-system of action in general' (p8). Turner makes passing reference to this set of relations and suggests that, as sociology has developed, the material or physical body has been subordinated by the metaphysical body, or the social self. The claim made here is that within general theory, the body is clearly conceptualised as an important analytical category, for instance, in relation to its responses to disease, and the implications of these for social roles. It is, however, subordinated by reference to the agency character of social action, in which the body follows decisions made by its inhabitant or those responsible for its social maintenance, for instance, within medical culture. Hence, Turner's discussion of Parsons acknowledges the analytical potential for developing the notion of embodied agency, but simultaneously identifies a dualism between body and self.

Yet a rereading of Parsons suggests that the body is placed as a more *explicit* and critical focus for analysis, in which the organism, or the body, can be understood as the ultimate condition for social relations. Indeed, Parsons outlines the body's place in his hierarchy of control in which cybernetic systems, *high* in information but low in energy, *regulate* other systems higher in energy but lower in information (p9). Parsons himself appears much less ambivalent about the status of the body in relation to both social action and formal analysis. For instance, he asserts:

'...we know the physical world *only* through the organism'
(emphasis in the original, 1966, p8)

The implication here would appear to be to highlight the body as an unchanging basis for social action. Yet, simultaneously, there is considerable ambiguity in such a statement, which not only identifies the body as a *condition* for human action, therefore fulfilling the 'absent presence' to which Turner refers, but also as a *construction* of human action. Whilst Turner acknowledges the body in Parsons, by assuming that Parsons reproduces the Cartesianism inherent in formal theory, he fails to recognise the analytical potential which Parsons' work provides.

It is not that the body is bracketed out in Parsons' general theory, although clearly a dualism is apparent. However, it is a dualism between *condition* and *construction*, or between the universal and the particular, rather than between mind and body. The statement here points to the body as both a condition of action, which Turner also finds in Weber (1978), and as a means of interpretation. Therefore, Parsons's insight here, unintentionally perhaps, draws attention to the necessity of a sociological treatment of the body in the development of general theory. However, whilst the body has been addressed as a condition for social action its theoretical development remains in nascent form.²

Running through discussion of the ontological and epistemological status of the body is a major unresolved tension between the biological and the social, the body and embodiment. A key issue for analysis has been the implications of reproducing Cartesianism in sociological theory (Freund, 1988) and the validity of sociological knowledge about the body. The reproduction of this legacy has produced a particular version of sociological theory which is premised on an implicit acknowledgement of the importance of the body to human action, but at the same time, a refusal to incorporate the body into its analytical categories.

Interpretive Traditions

Whilst general sociological theory has developed by acknowledging the body as a condition of action, but ultimately failing to incorporate the body in its categories, other sociological traditions have highlighted the analytical importance of the body. For instance, sociology, although less concertedly than anthropology, has dealt with the cultural meanings bestowed upon the body (Crawford, 1984), or how the body operates as a medium through which social reproduction, control and order is shaped. Drawing on anthropological approaches to the 'lived' body and its symbolic relationship to the social world, phenomenological sociologists have also been concerned with the issue of how 'being-in-the-world' is crucially linked to embodiment.³

² See Berthelot (1986) for a discussion of the body in social theory which traces the sociological encounter with the body.

³ Merleau-Ponty (1962) in particular provides discussion of the 'openness' and beingness of the body and its relationship to the social world.

Social constructionism and symbolic interactionism also highlight the importance of the human body for social expression and interaction, for making and remaking social life. Turner (1992) acknowledges the influence of the work of both Goffman (1959) and Berger and Luckmann (1967) which he argues should be seen as nascent versions of a sociology of the body.⁴ Goffman, for instance, positions the physical body as a surface or a filter through which expression of self is performed and acted out. Phenomenological approaches also allow us to address the body as a dialectic of *being* and *having* a body, and provide a means of examining the relationship between social actors and their physical bodies, which can be seen as both constraints on, and capacities for, action. This approach is elaborated more recently by Shilling (1993) and others.

Whilst these traditions address the body in more explicit terms than those deploying the categories of general theory, it remains the case that the organic basis of the body is seldom under question here. In common with general theoretical traditions, within phenomenological or interactionist approaches, the ontological status of the body is not problematic. It is understood as a stable organism which supports or constrains interaction, or it is seen as an organic means of production. Indeed, it is taken for granted, in ways which perhaps tell us about the social power of medical knowledge and the extent to which medical culture has successfully contested the body as its own legitimate territory. Consequently, sociology has accepted the assumptions of biomedicine, and has bracketed out physiology and biology, either real or apparent (Freund, 1983).

Some anthropological traditions acknowledge the way in which the body is bracketed out as a pre-social entity, and in so doing, attempt to (re)centre the body as the focus of analysis. For instance, the work of Mary Douglas (1970), has focused on the the notion of the body as a symbolic representation of the social and moral world, and others have posed the body as a narrative of social processes (Scheper-Hughes and Lock, 1987). From this work the concept of embodiment has developed

⁴ Freund (1988) makes the point that whilst Berger and Luckmann (1967) utilise phenomenological concepts, such as those developed by Merleau-Ponty, in their discussion of the 'openness' of human nature, they do not develop this into discussion of the social construction of bodies.

(Csordas, 1989), through which social actors experience social, moral and political exigencies. Nevertheless, despite attempts to re-negotiate the analytical status of the body, the body present in this work must also be seen as a relatively stable organism. Certainly it is variable in its interpretation, for instance, through medical language and perceptions, but is complete, of and in itself. This observation returns us to Parsons' insight, and reminds us of the potential of the complex model of social hierarchy he developed, in which the organism, or the body, might be seen as the ultimate condition for social relations, which in turn, can only be understood *through* social relations.

Social constructionist approaches to the body have, in the main, addressed the surfaces of the body, the interface between the corporeal and the social, leaving the biological/organic basis of disease, sociologically intact. This perspective, adopted by essayists in the Wright and Treacher (1982) collection for instance, addresses the social conditions in which diseases and illnesses emerge, rather than disease itself, and the ways in which they are socially created, through interests which shape responses to disease. For instance, Brandt's (1985) work on sexually transmitted diseases, demonstrates how disease can only be fully understood as both social and biological phenomena, or as the outcome of socio-historical processes. Here, however, the body and its social context work in parallel, with no explicit interaction between them.

The work of Elias (1978) on civilising processes, challenges the view of a stable body by posing the body as an organism which is constantly changing across historical and biographical time (see also Shilling, 1993, for an overview). This notion of historically and biographically shifting bodies has emerged in work which explores bodily disruptions through chronic illness (Williams, 1984), and the ways in which embodied experiences have changed across time (through the emergence of new reproductive technologies; genetic screening; surgical techniques). Illich (1986) for instance, argues that the body has been objectified by medical understandings which have exerted a dualist monopoly in the twentieth century. This monopoly has increasingly contributed to feelings of alienation, which underlie a shift towards an understanding of the body in which people are encouraged to objectify themselves, by

internalising medical categories, and therefore locate themselves under a medical canopy (Turner, 1987). In this work, the stability of the body increasingly comes under question.

Therefore, within social constructionism, the actions and interests of groups and individuals are often under scrutiny, rather than bodies themselves. Whilst social structures provide the context in which knowledge is produced, for instance, within medical culture, nevertheless, knowledge is produced by individual actors with interests to secure and resources to gain. In this production of knowledge, the body is compartmentalised, as a means of securing territorial boundaries, and commodified, as a means of deploying technologies which are developed in order to secure new specialisms. The development of ultrasound, for instance, is a form of technological change which has contributed to the establishment of specialist boundaries. Oakley (1984) and McLeod (1986) demonstrate how visual images of the fetus enabled obstetrics to establish itself as a specialism separate from gynaecology, by partitioning the developing foetus from its mother and, consequently, posing a clear distinction between the body of the baby and the body of the woman carrying it.

Knowledge, Discourse and Deconstruction

Knowledge of the body, therefore, plays an instrumental role in securing professional, occupational or state interests, and is constructed in the light of prevailing dominant notions about, for instance, gender or class. Yet even within these frameworks, the social is mapped onto the biological and the body is not placed centrally as an analytic category, in need of examination or explanation. We begin to see this, however, where knowledge is scrutinised as ideology, particularly within feminist research, or where a 'strong' social constructionist approach leads to a firmer suggestion that medical knowledge can be 'made' in the laboratory as a consequence of numerous contingencies, rather than as the neutral product of a disinterested science (Latour and Woolgar, 1979). For instance, knowledge concerning the female body has been argued to reflect little stability about that body. The nineteenth century category of hysteria, for example, owed less to medical 'knowledge' than to the profession of medicine's patriarchal attitudes to women which were

linked to strategies to prevent women entering professional occupations (for a review of female entry into law and medicine, see for instance Sachs and Wilson, 1978).

Whilst these kinds of approaches have been criticised as obscuring the emancipatory aspect of medicine and reducing medical practice and knowledge to the appropriation of power (Scambler, 1987), they tend to address society rather than the body. In contrast, post-structuralist approaches challenge the stability of the biological order by questioning legitimacy claims and problematizing the facticity of the body itself. Post-structuralist analyses of the body have been more influential in the humanities perhaps, than within sociology itself, although there are a growing number of studies which take up post-structuralist positions and identify the social meanings of a given situation or object, including the body, as one of many possible social meanings.

These approaches draw attention to the ways in which discourses, for instance, medical talk and practices, do not reveal claims to truth, in any rationalist sense, but rather, reveal alternative discourses (Fox, 1992; Atkinson, 1996). Here, taken-for-granted assumptions of the social world are deconstructed to reveal the fragmentation of subjects and, furthermore, are done so in ways which demonstrate the author's awareness of the production of his or her text. In this approach to the body, diseases or bodily conditions cannot be regarded as natural events or facts which exist outside the language in which they are described or the historical context in which they reside (Benoist and Catherois, 1993).

Post-structuralist thinking poses the possibility of reading the body as a text and invites us to decode its inscriptions (Grosz, 1994). This approach to the body has been explicitly deployed within social history and the humanities. The work of Laqueur (1991) is seminal in this respect. His historical research on the body, drawing on Foucault, suggests a more radical position, in which the body we know collectively, or understand as a universal category, must be seen as a product of particular contexts and practices. For example, Laqueur argues that both historical and current understandings of gender differentiated bodies, stem from social shifts through which the body was rewritten in response to changes in women's

social and political positions. I will return to these arguments and how they have been used in feminist discussion of embodiment in Chapter Two.

The body has been identified as a target for rationalisation processes in the work of Marx (Freund, 1983), Weber and Foucault (Turner, 1992), through regulatory strategies and technologies of social control, through which power is imposed upon the soul (Rose, 1990). Foucault's work in particular, has opened up a way of exploring the interdependency of mind and body by examining the power of discourse to produce the body (Foucault, 1972), or the shaping of the body through social practices and contexts (Connell, 1987; 1995; Shilling, 1993), such as surveillance (Armstrong, 1983; 1995). In parallel with poststructuralist developments, Freund (1988) points to the interplay between phenomenology and historical materialism as a framework through which to capture the intersection of mind, body and society, and place the body central to analysis. Freund suggests the body should be seen as:

'...socially constructed in historically changing settings of production and consumption, and by the institutions that characterise these settings. Modes of social control as well as power relationships based on class, age, race, ethnicity and gender also play a significant role in the body's social construction.' (1988, p581)

There are parallels here with Parsons' attempt to integrate personality, social action and social structure. A focus on the interpenetration of the social and biological is posed as more fruitful than a 'strong' approach which casts the body as a 'pure' social construction. This view engages with a sense of a changing and unstable body across both historical and biographical time. In particular, the effects of the 'civilising process' are important here (Elias, 1978), since it may create distinctions and disjunctions between bodily states and our expression of them. It is not simply that the body has responses to stimulæ which social actors 'express', but that society intervenes to shape, and create the conditions in which responses can be made. As Martin (1984; 1989) so clearly demonstrates in her work on menstruation, pregnancy and childbirth, such a process may create and sustain a set of disjunctions between physiological states and the subjective experience of biology.

Here the facticity of the body is a constituent of action and interaction. This turns the social constructionist position on its head, by arguing that what we know of the body is not determined by knowledge which is produced by interests, politics, resources and social context, but that practices themselves, in historically changing circumstances, produce knowledges of the body. This turn towards the production of knowledge and hence the production of the body, has developed in a wider context of postmodernism, in which plurality and fragmentation are celebrated as facets of both social life and sociological theory.

Sociological theory concerned with the body has both fragmented and multiplied (Bertholot, 1986), as we see in O'Neill's *Five Bodies* (1985), which has been much mobilised in attempts to develop a sociology of the body. Overviews and introductions to the body now typically address different kinds of bodies. Hence, Turner (1984) identifies the 'discursive' and 'material' body; O'Neill (1985) addresses the 'individual/social', 'physical', 'communicative', 'consumer' and 'medical' body; Frank (1990) identifies the 'sexual' body and the 'disciplined' body; Frankenberg (1990) makes distinctions between the 'somatic' and 'corporeal' body; Shilling (1993) addresses the 'uncertain' body, the 'naturalistic' body, the 'socially constructed' body; Turner (1992) adds 'medicalised' and 'talking' bodies to his list; Lupton (1994) addresses the 'commodified' body and the 'regulated' body. Such an elaborate list of bodies underscores Shilling's observation about the 'uncertainty that sociologists have in identifying what the body is' (1993, p39) and illustrate Turner's (1984) difficulties in identifying the substance of the body. More significantly, however, they illustrate a failure to incorporate the body into the categories of general theory and draw attention to the way in which the development of deconstructive sociology has focused not upon the body, but upon discourse.

Therefore, there is a tension in the pursuit of an attempt to identify and know the body. Discourse is analytically central to this enterprise, yet the enterprise itself is profoundly modernist, and therefore stands in contrast to the discursive turn. Hence, a recurring issue within the sociology of the body is whether bodies exist independently of their social construction, or whether they exist only in relation to the practices which produce them. This concern is posed as a distinction between

foundationalism and anti-foundationalism within the sociological literature (see Nettleton, 1992 for a discussion) and has been organised around the tension between the real or apparent body, and the status of knowledge in relation to the body.

Turner (1992) highlights this problem and argues that the development of a sociology of the body has replicated a dichotomy between whether it is real or constructed. His resolution to this tension has been to accept a body which is *both* an organic entity *and* socially constructed. This resolution, however, as my discussion of Parsons illustrates, reproduces a distinction between the body as a condition for action and the body as a means of interpretation. This oversight limits sociological conceptualisation of corporeality (Berthelot, 1986; Freund, 1988), in which the body remains as a stable entity, undifferentiated across space and time.

What the reproduction of this distinction points to is the way in which the body and embodiment have been collapsed in sociological debate. Sociologists cannot ask the same questions of the body as it might once have asked of class, which have been fully reviewed and critiqued. So for instance, what class is, how it is manifest, and to what it relates, are not questions which may be easily translated to the body. Rather, sociological analysis is better placed by beginning with what individuals know of their bodies and how embodiment is experienced; how this shifts according to time, space and context; and why the body has become significant for sociology in late modernity. General theory and other sociological traditions have struggled to 'bring the body in' as a focus for analysis, but have failed to think about the reconstruction of categories, which is a condition of an adequate understanding. In contrast, both feminism and Foucault have produced a more explicit attempt to reconceptualise categories of analysis.

From the general to the particular

Some commentators have argued that the mind/body dualism to which sociological theory has addressed itself, is reproduced in the solutions it provides (Freund, 1988). First, as some have argued (Shilling, 1993; Turner, 1992), it becomes increasingly difficult to define what the body is, in late modernity. Its 'beingness' is uncertain and disappears. Second,

and relatedly, an emphasis on 'the' body, obscures the dialectic between body, mind and society. Douglas (1970) expresses this dialectic in the following way:

'The social body constrains the way the physical body is perceived. The physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society. There is a continual exchange of meanings between the two kinds of bodily experience so that each reinforces the categories of the other. As a result of this interaction the body itself is a highly restricted medium of expression.' (1970, pxiii)

In contrast, an *embodied* sociology would foreground the relationship between the experience of 'having' a body and of 'being' a body. Here embodiment serves not only as a bridge between voluntaristic action and the biological body (Berger and Luckmann, 1967), but crucially, is understood as the expression of a dialectic process, through which the body as both object and subject, in and of itself, can only be understood through 'the practices that conceptualise it, represent it, and respond to it' (Crimp, 1988, cited in Frank, 1990, p135).

Of emerging importance to debates around the status of the body in sociological theory is the way in which feminism is implicitly acknowledged as a form of social change which has forced body politics onto social and political agendas. Both the raising of body consciousness and the reclamation of the body as central to self and identity mark an historical turn in the relationship of the body to sociology. Sociologists have incorporated feminist emphases on embodied experience, in order to enhance the status of the body within sociology. Zola (1991) argues that this is a challenge for sociology which is as yet unfulfilled. He notes the:

'importance of women's perspectives in health care, man's domination in particular, the necessary breakdown of the split between public and private worlds, and the role of the body in one's identity.' (1991, p1)

However, this position takes its force from observations about embodied experience in ways which uncritically accept the notion of authenticity inherent within feminist discussion around issues of health. Furthermore, whilst feminism is acknowledged in sociology, it is not

addressed as central to the analytical categories which develop from it, and it has not been used to highlight the fundamental distinction which underlies the abstract categories of formal analysis. Nevertheless, sociology's acknowledgement of feminism can be developed to produce a shift in disciplinary consciousness, in which embodiment is foregrounded as the basis for social action and the medium through which it is understood. I will return to these issues in Chapter Two.

The body has also been central to debates in the sociology of health and illness which have developed Foucauldian frameworks to address the connections between health and society. In particular, sociological literature on surveillance examines changes in medical practices and perceptions, which in turn, have created new knowledges of the body. Hence, in this view, the body is produced through the development of new gazes, as a particular object, as a site for the application of power and as the material on which rationalisation techniques are applied. Through a sociological affirmation of Foucault, we see an implicit attempt to rework the categories of analysis to address both the body as a condition and as a constituent of action.

Regulating Bodies

Foucault and Surveillance

In sociology, as well as within other disciplines in the social sciences and humanities, Foucault's legacy is palpable. Perhaps more than any other theorist, Foucault embodies the 'postmodern turn', although he would not, perhaps, have cast himself in such a way (McNay, 1992). Yet, in attempts to critique 'grand narratives' and make flesh their demise, sociological theory which draws on Foucault, paradoxically, creates and reinforces a new 'grand narrative', a Foucauldian paradigm.

Within the sociology of health and illness, and within feminist theory, Foucault's influence is perhaps more keenly felt than in other sociological sub-disciplines. There are clear reasons for this. Whilst Foucault was not a sociologist, his work addresses areas of interest to both sociologists of health and illness and feminists, and he develops ways of thinking about power, knowledge and the body which have attractions for both groups. Some of his work directly addresses the relationship between medical

knowledge, power relations and historical changes in collective perception (Foucault, 1973) and the government of the body (1979). His work also directly addresses both the regulation of female sexuality in the context of a broader examination of the history of sexuality (Foucault, 1990), and issues of power, knowledge and the body (Gordon, 1980). In particular, Foucault has been used to examine the government of the body through techniques of surveillance.

Not only has the substantive and theoretical basis of Foucault's work been identified as important by feminists and sociologists of health and illness, but also his methodological and epistemological approaches. In particular, his framework provides a means through which to challenge liberal humanism. Turner (1992, p179) summarises Foucault's position as one which is critical of historical accounts which assume a teleological development, which see the development of rational knowledge as progressive, continuous and liberal, or as necessarily associated with improvements in human conditions (Silverman, 1989), for instance, through the welfare state. In contrast, Foucault stresses discontinuities in the development of knowledge and the exercise of power. To this effect, he emphasises the importance of discourse, calling into question the nature of knowledge and challenging the empirical basis of knowledge, including the body. He asserts discourses are:

'practices that systematically form the objects of which they speak...it is through discourses, that is, the mix of beliefs, ideas, and concepts which make up and organise our relation to reality, that power and knowledge come together.'
(Foucault, 1972, p48)

Drawing on this approach, sociologists of health and illness have scrutinized the independent pre-existence of knowledge, concerning the body, for substance. Nettleton (1988), for instance, uses this framework to explain the separation of the mouth from the body and the emergence of dentistry, and she suggests that:

'...the consequence of the mouth was not dentistry, rather dentistry produced the mouth.' (1988, p158)

Foucault's work has been used to examine how techniques of surveillance in the twentieth century have created new knowledges and orthodoxies in and around the body. The emergence of specialties and interventions, such as prevention, are explained in relation to the kinds of techniques they employ and the social context in which knowledges are created of and around the body. For instance, the development of clinical medicine, as a new form of knowledge, emerged from the birth of the clinic, as a particular kind of social space in which new practices were engendered. In this space, practices were institutionalised and knowledge made systematic, in ways which established control over the body.

Therefore, of particular significance for sociologists of health and illness, has been Foucault's work on the regulation of bodies, surveillance and disciplinary power. Foucault's thesis is this: the development of the prison system in the eighteenth and nineteenth centuries corresponded with a shift towards a new conceptualisation of the body, which in turn, produced changes in the relationship of the body to the state (Foucault in Gordon, 1980). A shift occurred here, from penalty within the enclosed institution, spatially established on the edges of society, towards the discipline mechanism typified by the Panopticon. The Panopticon, identified by Foucault as a new concept in penal surveillance, in general represented a minimal, but calculated, architectural constraint which created the capacity to see objects dispersed in a wide, heterogenous field (Foucault, 1979, p87). It represented a new form of control through the creation of fields of visibility, such as penalty or public health.

Commentaries on Foucault characterise the exercise of Panopticon power as lighter, more rapid, more effective, more subtle (Garland, 1990). Of particular significance for the sociology of the body, is the way in which the concept of surveillance draws attention to the observation and monitoring of populations, for example, by the state. The penal discourse to which Foucault makes reference, corresponded with a move toward greater surveillance of populations, and, indeed, the historical record identifies the emergence and expansion of, for example, public health as a move to the systematic monitoring of populations, on the part of the state (Fee and Porter, 1992). As practices changed, so understandings of the body shifted. For instance, the nineteenth century produced the body as a

solid invariable entity, via the practice of detailed microscopic analysis (Wear, 1992), and in the twentieth century, as medicine began to look upon the social spaces occupied by bodies, the potentially ill, or the otherwise healthy and normal, are sought out and monitored (Armstrong, 1983; 1993). Parallel to the emergence of more systematic provision for health care, through the welfare state, perceptions within medicine of new 'social' diseases created a corresponding need for surveillance, not only of those bodies in which disease might be localised, but also within the social spaces in which bodies were located (Armstrong, 1983, p33). Other sociologists also note this shift (de Swaan, 1990) and social historians make similar observations, albeit within different conceptual frameworks (Laqueur, 1991). Hence the localisation of disease *within* the individual body became the focus for medical intervention.

Therefore, Foucault observed an historical shift, from the eighteenth century, in the relationship between the human body and the state (Foucault, 1979). Greater surveillance of populations by the state, to which public health was central (Lupton, 1995), established a new principle of the 'body of society' (Scheper-Hughes and Lock, 1987). As Turner (1992) points out, population growth in North Western Europe throughout the eighteenth century created coordination and integration 'needs' for the apparatus of production (p20). These needs, associated with the development of capitalism, referred specifically to the regulation of health and longevity through the control over bodies, individual and collective, in reproduction and sexuality (Turner, 1984; 1987), in work and leisure (Freund and McGuire, 1991) in sickness and other forms of difference (Frank, 1990; Scheper-Hughes and Lock, 1987). Various authors point to capitalist development (Turner, 1987), the civilising process (Elias, 1978; Illich, 1986) and the requirement for precision and calculability (Weber, 1978) as the basis on which a new relationship developed between the body politic, the social body and individual bodies.

The regulation of the social body which this shift engendered, (symbolised, for instance, in public health), was shaped through agencies and practices associated with the prison, the school and the hospital (Lawler, 1991). In *Discipline and Punish* (1979), Foucault points to the growth of examinations, timetables, registers and classification systems as

a means of establishing detailed population surveillance. Sociologists draw on this insight to address the rapid growth in hospitals, which allowed increasing numbers of people to be organised and observed centrally, and which made the history given by patients secondary to clinical observation (Jewson, 1976). This shored up medical epistemology by providing an 'examining apparatus' which established a rationale to examine bodies physically. Hence the policing of populations through the examination became part of a new social order. This new order developed, argues Foucault, not as a consensus of wills, but as the:

'materiality of power operating on the very bodies of individuals.' (Foucault, in Gordon, 1980, p55)

According to Foucault, practices and knowledges of surveillance, through population observation and monitoring, regulate the phenomena they constitute. However, individuals are not coerced by the state to behave according to norms which it establishes. On the contrary, practices of surveillance, for instance through public health or welfare policies (see for instance, Hewitt, 1983) encourage individuals to observe and monitor their own behaviour. Foucault (1979) also, therefore, refers to self-surveillance, through which individuals come to behave in particular, specified ways through 'self-correction to norms'. It is this lighter mode of 'liberal governance' (Rose, 1990) which has drawn so much attention from sociologists and feminist theorists.

Foucault is seen as important because of the way in which he placed the body as central to the development of medical epistemology. He viewed the body as both the material on which agencies practice, such as medicine, and identified the ways in which the body provides a source for the expression and creation of self. Both *Discipline and Punish* (1979) and *The Birth of the Clinic* (1973) discuss how 'bodies' are constituted by disciplines, bureaucracies and the medical gaze, and therefore offer a challenge to the disembodied self of theory. Sociologists have used Foucault's work to more directly address the body's 'absent presence' in sociological theory and undercut the abstractions which are seen as part of the sociological project. In particular, his work has provided a means of conceptualising the emergence of the individuated, autonomous self, created by surveillance and self-surveillance. By providing a framework

for sociological exploration both of those practices which constitute the body, and those which contribute to the constitution of self, by inviting individuals to govern themselves, the marriage of Foucault and sociology has been seen as a way of reinstating the commensurability of mind and body.

Some of the clearest statements in this regard can be found in the sociology of health and illness. The work of Armstrong (1983), Nettleton (1992) and Arney and Bergen (1984), have all contributed to a way of examining the relationship between the body and society, regulation and surveillance. Such work has focused on practices and perceptions which have shaped medical knowledge, which in turn have established a regulatory imperative towards 'health' (Lupton, 1995). Health, in this work, is conceptualised as a new social value (Crawford, 1984), through which bodies are regulated and identities formed. Prevention is critical to this regulatory imperative. In what follows I detail the conceptual use of surveillance in the sociology of health and illness and draw attention to the reproduction of tensions in Foucault's work which have implications for the status of the body in sociological thought.

Mapping Surveillance

The Clinical Gaze

Armstrong's early work identifies perceptions of a new body from the eighteenth century (Armstrong, 1983, p6), and draws heavily on Foucault's version of the status of the hospital clinic in eighteenth and nineteenth century Paris. Armstrong's thesis is that a new form of anatomical recording provided a different perceptual framework through which to read the body, establishing a different language through which the body could be interpreted. This language developed because the body became increasingly accessible through physical examination and the analytical rigours of pathology, in which corpses were opened up in the name of scientific observation prior to the observation of the bodies of patients. Armstrong draws attention to the 'medical gaze': many bodies were observed through a new visualisation process which viewed them singly. The practices underlying the medical gaze included: the physical examination, anatomical recording, the location of individual bodies within hospital space.

Armstrong (1987) describes these processes in some detail in order to provide a clear statement of disciplinary power, which, he argues, manifests itself through relations of observation. He therefore draws attention to the disciplinary practices which establish conditions for the analysis of the body. The Dispensary, for instance, was a model clearing house for the care and treatment of tuberculosis in the late nineteenth century, through which it became possible, theoretically, to observe and examine patients and their contacts. Armstrong deploys the tuberculosis Dispensary as a device through which to perceive the new form of social organisation, embedded within social medicine, and later institutionalised within health centres (1983; 1995). In detailing such processes, Armstrong argues that those under surveillance transform their identities and actions.

Drawing on Armstrong, Nettleton's (1992) study of dentistry develops this argument further and demonstrates how the mouth came to be policed: through the examination, or dental check-up; measurement and comparison through dental epidemiological records and the production of dental 'norms'; and through the power of the toothbrush drill. Importantly, the agents of surveillance within the parameters of disciplinary power are not only dentists, general practitioners, health visitors but also women as mothers, as they develop diligence in the monitoring of their children's teeth (Nettleton, 1988). This is a significant demonstration of surveillance both as centralised coordination which individuates subjects, and as disciplinary power which creates subjects.

Similarly, Arney (1982) emphasises the power of the perceptual framework in the classification of disease and bodily normality, and links changes in perception to the professional development of medicine. He argues, for instance, that in response to the ever present threat of midwifery, obstetrics narrowed its gaze to focus on internal body space, circumscribed by the uterus and pelvis, and sought ways to 'foresee pathology and act prophylactically' (p51). His work points to a shift in the status of pathology as the arbiter of medical knowledge, an observation similarly noted by social historians (Sturdy, 1992). Within obstetrics, the control of technology formed the basis on which professional position was secured. However, in contrast to arguments which locate professional

specialisation within technological imperatives (such as McLeod, 1986), it is worth noting that such control emerged as an outcome, rather than as an explicit goal, within professional specialisation processes. This developed synergistically, through the incorporation of other subjects who internalised and reproduced the specialist knowledges of these disciplines, which in turn, incorporated non-specialist knowledges as part of obstetric discourse.

This version of the professional development of obstetrics also emphasises the perceptual framework through which obstetrics 'sees' its subjects, a framework in which pathology is presumed to abide in the body, waiting to be revealed as 'truth'. The development of foetal monitoring, listening to the heart of the developing foetus through an instrument designed, in 1819, for auscultation, allowed obstetrics to incorporate pregnant women as 'joint adventurers' in its project (Arney, 1982, p100). This intervention attempted to *prevent* pathology developing, and relied on the establishment of categories of normal and abnormal, in order to place subjects within classification systems. Arney argues that this development in particular, allows a 'new mode of social control' over childbirth, one which is softer and lighter, because it extends into a wider community of reproductive women, with that community's consent. Its location within a preventive discourse, provides a route into wider aspects of women's lives, and increases the births which are subject to the obsteric gaze. This process of 'normalisation', of which Foucault was critical (Turner, 1995), subjects individuals to monitoring and observations, with a view to classifying them in *degrees* of normality/abnormality. Significantly, however, normalisation processes invite women to participate in their own observation as active collaborators, or as agents of prevention. Prevention in obstetrics or community medicine was concerned with identifying the potential for pathology in the community, rather than hospital space, in which the experience of being examined became normalised and routine.

Power/knowledge

'...power is not a structure, or a certain force with which certain people are endowed; it is a name given to a complex strategic relation in a given society.' (Foucault, quoted in Gordon, 1980, p27)

Foucault has drawn attention to the nature of power and pointed to the exaggerated role given to repression. Foucault defines power, in the first instance, in relation to what it is not. Bell (1993) suggests that power for Foucault should not be seen as repressive or as a force held by a subject which is used to censor, block or exclude. Therefore, power should not be understood as centralised, coordinated, or exercised by groups or individuals over others, and is no longer embodied in the rule of law (Smart, 1990). Rather, Foucault redefines power, in the second instance, as a force producing effects at the level of desire and at the level of knowledge.

Power/knowledge are bound together within the expansion of surveillance, such as that expressed by preventive strategies. A power to control is integral to a power to know, or to know implies the potential for control, which in turn, is made possible through mechanisms of surveillance. Within Foucault's rubric power is never still, and indeed, could be seen as somewhat circular, in the sense that:

'...the individual which power has constituted is at times its vehicle...' (Foucault, quoted in Gordon, 1980, p91).

This foregrounds the participation of the individual in his or her own bodily discipline and the ways in which people govern themselves and how they are governed by others. Supporting such governance are the production of technologies in the formation of knowledge: the methods of observation used, the social spaces in which observations are made, the techniques of investigation and so on. These conceptual elements of power/knowledge are common to the sociological studies of the body and governance which I have cited here.

The advantage which is attributed to power/knowledge is that power is seen to be exercised in ways which produce knowledges. Hence the body is discursively produced through the exercise of power, constituted

through particular discourses. Effectively, power/knowledge underpins processes through which the self creates itself as an object, thus implying a more fluid notion of subjectivity. For instance, as patients become partners in medical culture (Armstrong, 1979; 1984) through, for instance, preventive programmes, they draw on medical discourse to articulate their experiences, and engage in a dialogue with medical culture, in ways which reinforce their recruitment to the management of their own bodies. Surveillance here is seen as a form of social organisation which establishes a degree of enclosure or confines people to certain conceptual categories, in ways which ensure they internalise power/knowledge (Nettleton, 1992).

The conceptual utility of power/knowledge allows, indeed urges, a detailed focus on practices, or the 'meticulous observation of detail' and the 'political awareness of small things' (Foucault, 1979, p141), and their location within discourse. This emphasis on minutiae has the effect of shifting analysis from interest-led developments in medical knowledge, such as with social constructionism, to the practices through which such interests are engendered. Such a methodological gesture has the effect of locating medical developments, such as public health and prevention, and the body, as outcomes and effects, rather than as technological imperatives or as a stable entity. This avoids locating medical practice and knowledge within relations of domination, and interjects a critique of Enlightenment reason, in which the accumulation of scientific knowledge is linked to notions of progress.

Creating Subjects

The 'fabrication' of the autonomous individual is a prerequisite for the humanist versions of liberation of which Foucault is critical. Foucault's main point here is to establish the relation between 'soft' surveillance and social order. The prisoner, in the panoptic system, is obedient under the threat of observation (Foucault, 1979). This is later elaborated when Foucault (1990) asserts that any subjection to a field of visibility creates an ever present 'incitement to discourse', since the field contains within it technologies for extracting information. One is invited to 'confess all', so that a 'grid of observations' can be constructed and individuals located within it (Foucault, 1979). The invitation to subjects to enter into the

construction of their own subjectivity within the field of visibility, hence appears as liberation rather than restraint. This notion of confession has been elaborated most clearly by Armstrong (1984), although it is also developed in more recent work on sexuality (Bell, 1993; Weeks, 1986).

If practices of seeing produce new knowledge, then the developing practices stemming from new knowledge reinforce dominant ways of seeing. Disciplinary mechanisms, through which individuals are drawn into surveillance, transform subjects through the new actions and thoughts which are engendered, in which surveillance effectively reconfigures individuals 'through their constant and pervasive observation' (Foucault, 1979, p71). Furthermore, subjection:

'...is born mechanically of a fictitious relation...The efficiency of its power, its constraining force, have, in a sense, passed over to the other side - to the side of its surface of application. He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power. He makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection.' (Foucault, 1979, p202).

In this extract from *Discipline and Punish*, Foucault introduces a shift from surveillance to self-surveillance, which read through the context of public health, moves from state regulation and population monitoring, towards disciplinary power and self-surveillance. This shift highlights a key tension in Foucault's work between discourse and subject. There are provisionally two forms of surveillance working in parallel, which Foucault implies in his discussion of the distinction between regulatory and disciplinary power. Indeed, the concept of the Panopticon which Foucault mobilises as an image of a softer version of power, also encapsulates a notion of centralised knowledge. Yet it is precisely the idea of centralised knowledge and juridical power of which Foucault is critical, particularly through discussion of a shift *towards* self-surveillance *from* surveillance.

It is important to note the analytical shift here from surveillance towards self-surveillance as a process in which subjects come to locate themselves as active participants and knowledgable subjects. Subjects within this logic, are separated, individualised, made socially visible and offered

technologies, such as the toothbrush drill or foetal monitoring, which have the effect of normalisation, because of their increasingly widespread use and the expansion of their deployment in new social locations, such as the health centre. Normalisation, through disciplinary power, subjects individuals to monitoring and locates them within deviations based on probabilistic distributions (Armstrong, 1995). Hence, disciplinary power conceptualises the ways in which institutionalised disciplines look at bodies, describe and assess them, and how the application of such power is met with 'multiple resistances'. It is significant, however, that whilst this approach, with the exception of Arney (1982), draws attention to the conceptual utility of disciplinary power, it appears unable to identify the 'multiple resistances' which such power is said to engender. The studies I have cited are unable to identify resistances because of the way they have tended to focus on *practices* of surveillance rather than the *experiences* of self-surveillance. Consequently, and significantly, any sense of the resistances which power/knowledge are said to produce are obscured. As Section Three will demonstrate, when we acknowledge this oversight, previously obscured aspects of experience come into view.⁵

The apparatus of surveillance is seen to increasingly contribute to *self-surveillance* and conformity to the norms created within particular discourses. Normalisation invites the patient to 'confess', producing new levels of intimacy which enables the continued examination of bodies, through, for instance, ante-natal care. Foetal monitoring, for instance, is not understood here as part of a medicalising process (Zola, 1972), but as part of a new organising concept which incorporates reproductive women as participants, and thus increases their visibility. Yet the emergence of self-surveillance raises questions about responsibility and attribution; and the relationship between empowerment and choice. On the one hand, women are placed as active subjects who may be empowered to exercise 'choice' in their experience of pregnancy and childbirth, through the information and knowledge shared in the monitoring process. On the other hand, if women are active participants in their pregnancy and labour, issues of responsibility are raised in relation to outcomes, which may themselves become more uncertain. Hence, the discourse which

⁵ For a discussion of resistances in relation to welfare surveillance see Bloor and McIntosh (1990).

creates active, participant subjects, equipped with shared knowledge to enable 'choice', simultaneously creates subjects on whom responsibility may be placed. Such an argument draws attention to the neo-liberal logic into which more recent Foucauldian arguments have become locked (for instance, Rose, 1990). Furthermore, this insight raises the status of embodiment, precisely because, as Greco has pointed out (1993, p361), in this new context, patients have to be more aware of their embodied experience and become skilled at translating this into medical discourse.

Conclusion

The sociology of the body has developed analytical frameworks through which to address medical power in relation to bodily regulation, without conceding such power to be interest-driven. The work cited here has focused, largely, on enterprises which have produced preventive regimes: for instance, the development of pathology, community medicine; dentistry; and obstetrics. It has addressed the body as a site of surveillance and of transformation. Similarly, power/knowledge has a dynamic quality which could also be read as a dialectic. Specific analytical claims are made in relation to concepts derived from a Foucauldian approach and their utility for unpacking surveillance. Such claims have importance, first, because medical practice is approached in a way which acknowledges the salience of professional power and interests in the development of knowledge, but also emphasises the importance of everyday conflicts, struggles and unintended outcomes in the creation of new ways of seeing and fresh practices. Second, such work is important because of the potential for incorporating the notion of resistance to practices and knowledges, within the analytic framework. Whilst the first claim is largely met, considerable shortfall exists in the claims of the second. For Foucault, the body enters:

'a machinery of power that explores it, breaks it down and rearranges it. A "political anatomy" which was also a "mechanics of power", was being born.' (Foucault, 1979, p138)

Furthermore:

'The exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces the effects of power.' (Foucault, quoted in Gordon, 1980, p52)

These two statements represent the tension in Foucault's discussion of surveillance and power. In addressing the expansion of population surveillance and bodily regulation, the sociological literature on the body has deployed both disciplinary power and the medical gaze as key concepts through which to examine social process and change. In Foucault's work, surveillance, as an aspect of regulatory power or later, as an aspect of governance, is a machinery of discipline. It is the 'meticulous observation of detail' and the 'political awareness of small things' which underpin social regulation; it 'generates a whole corpus of methods and knowledges, descriptions, plans and data' (1979, p141). It therefore incorporates both the coordination of information and knowledge for the purpose of regulating populations and the constitution of mechanisms which encourage individuals to moderate and govern their own practices in line with dominant discourse.

The work of Foucault examines the nature of power and the way in which it has changed historically. This insight is developed most critically in relation to medical practice, knowledge and health, where 'biopower', signals a transition in the form of power itself, from a coercive and sovereign force, to one which is lighter and more localised in its effects. However, whilst this work details the development of surveillance and its relationship to power/knowledge, it does so on the basis of observations made about changes in medical *practice*. These observations are, in turn, a consequence of merging the notions of both clinical gaze and the Panopticon to produce a more unified analytical framework than is warranted (Osborne, 1992).

Foucault's work, significantly, retains a tension between surveillance and self-surveillance, which is reproduced in sociology, when applied to the body and health, in order to satisfy a particular logic of analysis. We see this most clearly when sociology uses the concept of disciplinary power to address social action and suggest that individuals become active participants in the monitoring of their bodies and in the production of health. The focus on self-surveillance is filtered through discussions of medical discourse, practices and techniques, and draws attention to practices of self. It fails, however, to demonstrate the *experience* of self-surveillance, and thereby reproduces a dualism between the body and

embodiment. Therefore, despite the analytical importance of the body in this work, sociology has reproduced a tension between surveillance and self-surveillance, and indeed between the body and embodiment, in the way it has focused on *practices* of surveillance to the neglect of *experiences* of self-surveillance. This attention, consequently, obscures responses to surveillance, to which Section Three will return.

An overemphasis on practices associated with historical change in the nature and perceptions of the body has prioritised the importance of medical practices over the experience of those practices. A consequence is that this work has created a somewhat disembodied approach to those issues of the body which it has addressed. Furthermore, there has been a tendency to uncritically accept the context in which surveillance has been set. This oversight makes it difficult to locate experiences of participation and membership in the domain of health, therefore resistances are both neglected and undertheorised.

In addition, this work has not explicitly addressed the gendered nature of power, nor the relationship of gendered bodies to regulating processes. With few exceptions (Bordo, 1989; Holland, Ramazanoglu, Sharpe and Thomson, 1994), sociological work on surveillance has failed to address the specificities of the regulation of female bodies, or how regulation creates specific identities for female subjects. There is, certainly, an inference within Nettleton's (1991) work that female subjects are differentially marked out as mothers and guardians of children's teeth within preventive dental discourse (see also Graham, 1979). Armstrong (1983) too alludes to this as he addresses female subjects as carers in the community, but neither place gender as a central category in their work, and are, therefore, unable to demonstrate the internalisation or negotiation of the identities attributed to them.

In conclusion, sociology has been a science of action, where general theory has addressed the body as a condition of action. However, even in Parsons' general theory, we find a stronger notion of variability and difference in his notion of the cybernetic hierarchy, which implies the body as a construction. A stronger version of the body as a construction is found in social constructionism and symbolic interactionism. These

approaches point to embodiment as variability, rather than as simply a condition of action, and demonstrate a shift from 'Knowledge' to *local knowledges* as categories of analysis. Yet, despite some acknowledgement of the body as both condition and construction, the body in general theory ultimately retains its sense of the *general*, therefore the sense of particular, local *embodiment* is disregarded.

In contrast, Foucault's work provides a stronger statement of construction and variability, which sociologists have found valuable in their attempt to 'bring the body in'. This work has focused on regulation and governance, particularly in relation to public health and prevention. Critical to this work, is the implicit shift from surveillance to self-surveillance and the implications of this for considering gendered subjectivity and embodiment. However, this shift is equivocal in Foucault's own work. Therefore sociological affirmation of Foucault has tended to reproduce both this tension and the distinction between condition and construction implicit in general theory. Furthermore, Foucault's attempts to address power relations do not deal directly with issues of power and gender, or how this relationship might be experienced and negotiated. Hence, whilst the sociology of the body pays lip service to feminist insight it has failed to read feminism as a strong statement of gendered embodiment. It is to this statement which Chapter Two now turns.

CHAPTER TWO
FEMINIST DISCOURSE - FEMALE EMBODIMENT
Historical Transformations of the Body

Feminist Theory and Sociology

As Turner and others (Shilling, 1993; Frank, 1990) see it, feminism has foregrounded the relationship between the body and society in a number of ways. First, feminists have argued that femininity has been aligned with 'nature' and they have therefore posed a distinction between sex and gender (de Beauvoir, 1972; Oakley, 1976). Second, alongside what Turner calls 'the feminization of life' (1992, p46), the female body has been politicised through the expansion of technological possibilities which recast the potential of bodies by providing support for alteration and intervention. In particular, the revolution in technically assisted reproduction foregrounds the malleability of bodies and their position within formal and informal systems of regulation. This revolution has been read as a form of 'biopolitics' (Foucault, 1979; 1990), but this also draws on earlier feminist work on the regulation of female reproduction (for instance, Firestone, 1972). Furthermore, debates and struggles around access to abortion (Gordon, 1976), the commodification of the female body in pornography (Dworkin, 1981), prostitution (Edwards, 1993) and more recently, surrogate motherhood (Singer, 1994) has made female embodied experience more visible as a topic for sociological analysis.

This politicisation of the body has occurred alongside, and in connection with, the way in which consumption patterns have developed in the latter half of the twentieth century. For instance, Featherstone (1982) has mapped out the ways in which the surface of the body increasingly plays a prominent role in marking out social identities, through practices such as dietary management and sport. Other work draws on Bourdieu (1984) to demonstrate how these practices shape bodies in line with Western value systems of thinness and fitness (Shilling, 1992), and in turn, contribute to the production of social distinction. Linked to shifts towards consumption as a key characteristic of late modernity, has been the way in which ageing is obscured as a social and biological process. 'Sequestration' of the ageing body from public life (Shilling, 1993), has engendered work on ageing as a process which individuals are under pressure to conceal and

manage (Featherstone and Hepworth, 1991). This process is thrown into relief by consideration of feminist debates around menopause (Lewis, 1993) and technological 'solutions' to ageing such as hormone replacement therapy (Hunt, 1994) and cosmetic surgery (Davis, 1994).

Finally, the body has also been made more visible through postmodern culture and the emergence of a context of sexual anxiety. The development of HIV/AIDS has raised questions about the security of the body and has provoked debate about body invasions and the need for body regulation (Kroker and Kroker, 1988; Martin, 1990; Haraway, 1989). Alongside the internal bodily regulation and control which, arguably, late modernity and rationalisation has ushered in, is a range of uncertainties around meaning and risk (Giddens, 1990; Beck, 1992). In conjunction with new abilities to control and reshape bodies, from cosmetic and transplant surgery (Davis, 1994; Helman, 1991; O'Neill, 1985), to artificial insemination, the body is increasingly the focus for anxieties about safety and security. Such anxieties are typically manifest in popular culture where body boundaries are identified as problematic and unstable through visual representations found in such films and television programmes as *Terminator*, *Alien*, *The Silence of the Lambs*, *The X Files*.¹

This focus on boundary security in general engages with fears about the female body in particular, as lacking secure boundaries, and with feminist arguments about the fluidity of female body boundaries (Kristeva, 1982). This concern has also been explored in feminist fiction in ways which suggest that the boundaries of the female body point to more open and connected social relations (Atwood, 1986; Piercy, 1979). Of particular concern for feminism are the boundaries between the body and self. The publication of and response to the Boston Women's Collective classic, *Our Bodies Ourselves* (Phillips and Rakussen, 1971), illustrates the point that feminist scholarship has emphasised connections between practices on the corporeal and their affect on the existential (Bordo, 1993; Lupton, 1994). Furthermore, the cyborg has been endowed with positive virtue in academic texts (Haraway, 1990), as a potentially productive fusion between

¹ Concerns around body boundaries in feminist film theory predate concerns within the sociology of the body (for instance, see for instance essays by Kuhn, 1985).

bodies and robotics, in ways which will stimulate new 'hybrid' identities. The journal *Body and Society* has recently provided fertile ground in which to develop discussions of cyberbodies.

Hence in contrast to general theory, feminism has been both implicitly and explicitly concerned with female embodiment and has sought to examine the ways in which the female body interacts with the social world. As I argued in Chapter One, whilst sociologists pay notional tribute to feminist theory in the development of body sociology, they underestimate the extent to which feminism has addressed practices which explicitly confront the status of the female body and embodiment (Stacey, 1988; Lewin and Olesen, 1985; Oakley, 1980). For feminists, focus on the body as a site of struggle, as the material basis of social and individual rights, has been of particular importance and is largely formulated through a critique of Cartesian dualism. Within feminism, we find a strong statement of variability and gendered embodiment, through work which addresses medical practices which respond to, represent, and shape understandings of the body.

In what follows, I explore this statement through two kinds of feminist argument in relation to health and medicine. First, feminist debate has drawn attention to the historical transformation of the female body into a body open to expert scrutiny. Scientific rationality and medico-legal culture have contributed to this transformation and are identified as discourses which have differentiated male and female bodies on the basis of biology. Such differentiation has been linked to the maintenance of public/private dualisms which place the female body in the sphere of nature and sustain social divisions between men and women. A further dualism generated in this regard, and subject to critique, is that between embodied femininity and disembodied masculinity.

A second, though often implicit, issue in feminist scholarship, has been the ambiguous status of the female body in relation to social membership and participation. At the core of feminist discourse around women's health and the female body has been a political need to address the basis of gender. This has taken place through, on the one hand, a denial of materiality in order to liberate the female body from what was perceived

as the shackles of reproduction (de Beauvoir, 1972), and provide a route into the public sphere and the marketplace. It has also, more recently, taken place through a reclamation of the specificities of the female body and its daily lived experiences, in order to ground difference as a resource for social change and to enhance social participation (for instance, illustrated in Rich, 1986). There is a well defined literature addressing issues of female embodied experience and social control, in the context of health and illness. Strategies for addressing social control include education, the encouragement of 'women's knowledge' based on the experience of female embodiment, and the empowerment of women to challenge perceived bodily restrictions. These kinds of strategies mobilise a liberal model of citizenship in which empowerment plays a critical role, to which Section Two will return, through a discussion of its significance to the substantive issue of cervical screening.

Problematizing the Female Body

A key issue for feminist scholarship in sociology has been to argue that gender is a product of, and sits between, historically located dichotomies (Sydie, 1989). Enlightenment thought, in particular, has been subject to feminist critique as the intellectual and philosophical context in which dichotomous ideas about men and women were formed and consolidated (Jordanova, 1980). Whilst different political perspectives have underpinned the development of feminist thought, at the core of much debate has been this dichotomy, familiar by now to most readers of feminist texts: nature/culture; mind/body; masculinity/femininity. Of particular significance in historical processes of gender differentiation, has been the relationship of the body to systems of thought, ideas and practices.

A growing corpus of sociological, social and cultural historical, and literary scholarship has drawn attention to historical processes and systems of representation through which male and female bodies have been subject to differentiation. For instance, pre-Enlightenment medical illustrations and knowledge display a considerably less differentiated body than contemporary scientific and medical images represent (Jordanova, 1989; Gallagher, 1987). Skeletal and anatomical representations of male and female bodies were more marked by their representational similarity

than through their differentiation (Schiebinger, 1987; Shildrick and Price, 1994). It should be noted that this stands in contrast to feminist debates within art history which point to the inabilities of male artists to faithfully represent the female body prior to the Enlightenment (Pointon, 1986). Furthermore, this understanding of the similarities between bodies should not be taken to support a view that pre-Enlightenment eras were less patriarchal than post-Enlightenment eras, but that the character of patriarchy varies historically, and epochs may be associated with different perceptual frameworks.

The period between the sixteenth and the end of the eighteenth centuries, however, was characterised by rapid and extensive social change in relation to the nature of knowledge and the social position of women, as well as broader shifts in the meaning of culture, nature and civil society. Knowledge, based on empirical observation derived from the senses, was increasingly perceived as essential for the improvement of the human condition, and scientific and medical thought was crucial to the development of this notion (Jordanova, 1980). Eighteenth century scientific thought became preoccupied with anatomy which was contained within a hierarchical model of thought (Jordanova, 1989). Anatomy concerned itself with the functioning of body parts and how the body fits together. Its focus on dissection shored up this concern and enabled practitioners to explore the 'invisible' layers of the body, in ways which underpinned the development of a new perceptual framework in medicine (Armstrong, 1983). Stafford (1991), highlights more general processes at work which helped to transform perception and ways of thinking about the world.

Processes of historical transformation are key to understanding contemporary feminist discussions of gender differentiation. Jordanova (1989) argues that this period was one in which crucial dualisms were engendered and later crystallised. Schiebinger's work on the skeleton (1987), for instance, suggests that skeletal differentiation appeared at an historical point when women's social positions were being redefined. Socio-political shifts in the position of women were deployed as the basis for designating bodies as differentiated (Shildrick and Price, 1994). Ovaries, were, in particular, marked out as the anatomical carriers of this

difference, and femininity was associated with animality and nature. However, different body parts have been emphasised in different historical periods. Whilst the uterus was an important symbol of femininity in the nineteenth century, and central to public debates about women's social position, breasts were important in the eighteenth century as a symbol of maternal femininity and the social importance of nurturing (Jordanova, 1980).

Further support for this association between the female body and animality comes from Jordanova's (1989) work on scientific imagery. She argues that science and sexuality have been historically linked in ways which have produced a nature/culture dichotomy. In particular, the female body has become a basis for oppression, through practices of representation which increasingly differentiated male and female bodies. A key tool through which representation occurred was the wax model used for both teaching and drawing, which was made and presented in an increasingly differentiated way, marked by recumbency, jewellery, long hair and display on velvet or silk cushions. Cultural historians have argued that this form of representation was analogous to, and underpinned, the practices of scrutiny embedded in anatomy itself. The metaphorical use of the female body supported the development of a perceptual framework in which anatomical knowledge was created. Natural philosophy began to address phenomena in the 'natural' world from a privileged position from which it contrasted itself to religion. The mind became an object of celebration, in contrast to the body, which, it is argued, became associated with nature. This framework made the female body an object of scientific scrutiny, which in turn, was a vital component to the acquisition of knowledge in Enlightenment thought.

The thrust of these arguments is based on the notion that such imagery carries assumptions about gender and it is these assumptions which define the body in general and the female body in particular as an object of scrutiny. Work in this vein suggests that gender was first mapped onto 'the' body, then differentiated bodies were used to support arguments about social position and identity. This argument is made within cultural and social history but has also been made increasingly within sociological theory and feminist philosophy (see for instance, Delphy, 1993; Gatens,

1992; Grosz, 1994). This theme is also familiar in other approaches, for instance that of de Beauvoir (1972), in which the female body is understood as a repository for ideas, which are historically located within post-Enlightenment thought. However, the historical development of dichotomous thinking and the production of nature/culture dualisms have become reified in much of the feminist literature.

Divisions between nature and culture, were transformed in nineteenth century debates about the position of women in public space. The female body was explicitly seen by medicine and located within medical discourses in the nineteenth century as unstable (Poovey, 1987), the source of sexual pollution (Walkovitz, 1980) and inferior to the male body (Gallagher, 1987). These constructions were played out, for instance, in relation to issues of employment and prostitution. As women began to identify possible routes of entry into professional and political space, the female body was identified in professional discourse as a pathological body in need of containment and control (see for instance, Sachs and Wilson, 1978). The category of hysteria was a particular carrier for this pathological understanding of the female body, in which the uterus was seen through medical gazes as the seat of mysticism and symbol of femininity. Professional debate upheld middle class notions of femininity and was deployed to legitimise the exclusion of middle class women from the public sphere (for instance, see Turner, 1984). The *Contagious Disease Acts* of 1864 and 1866 identified the bodies of prostitutes as the carriers of disease, therefore as pollution and threat.

Distinctions between nature/culture were underpinned by the development of medical specialisms such as gynaecology, understood by contemporaries as the 'science of woman' (Moscucci, 1990, p5), through processes of specialisation and technological development which supported the idea of anatomical, physiological and psychological differentiation. Indeed, Moscucci argues that gynaecology in the nineteenth century must be seen as the legitimisation of dichotomised, prescribed roles for men and women: a modern medical discourse on the nature of women, developed around organs specific to female bodies. Furthermore, the development of gynaecology as a specialty within medicine and its centralisation within hospital space reinforced

reproduction as central to female embodiment in ways which separate the female body as conceptually distinct from the male body (Moscucci, 1990).

The historical development of obstetrics and gynaecology as specialisms established at the cost of midwives' knowledge and practice, has also been well documented (Donnison, 1977). The introduction of forceps (Wajcman, 1991) and the association of midwifery with witchcraft and superstition have, in particular, been identified within feminist discourse as key elements of the professionalisation of medicine and the deskilling of women's traditional healing abilities (Gamarnikow, 1978).² Deskilling such as this entrenched the notion of embodied and problematic femininity, in ways which have parallels with more recent examples of medical practice. Whilst there has been diversity in feminist critical approaches to modern medicine and issues of health, critique within sociology has largely developed through the concept of medicalisation.

The idea of medicine as an institution of social control has had a powerful influence on the nature of sociological enquiry around issues of health and illness. In this approach, classically formulated by Zola (1972), disease and sickness are seen as forms of deviance which must be regulated through specified and sanctioned agencies. Medicalisation expresses the processes through which medical culture encroaches on various aspects of life and to a degree wins consent for doing so (de Swaan, 1990). Illich (1976), elaborates on this idea and argues that in contexts of capitalist processes of specialisation and differentiation, medicine deliberately seeks to expand its boundaries and 'colonise' new areas of the body and mind.

The concept of medicalisation has proved valuable for feminist analyses of the female body and power, in particular because of its critical emphasis on medical knowledge and practice. Ehrenreich and English (1979) have

² Debates about deskilling, of course, have to be offset against arguments about the contribution of medical developments to reducing mortality and morbidity. For instance, whilst deskilling processes have clearly been at work in relation to women healers and midwives, infant mortality has been significantly reduced this century. However, it is also important to note that reproductive mortality in general has increased in the same period (see Beral, 1979, for instance, for a fuller critique). This undermines support for the contribution of specialist technology to the production of health.

argued that modern medicine has adopted the patriarchal mantle previously worn by religious institutions. Further, within this model of relations, in which sickness, real or constructed, is understood as deviance, medical culture defines the female body as an object. The female body is compartmentalised in ways which support the social construction of disease categories around the specificities of female embodiment. In medical culture, the female body has been targetted as a critical vehicle for expansion, through rational science and technological innovation.

As the female body is defined in terms of threats posed to the moral and social order, so there is a concomitant construction of 'women's complaints' which reinforce the instability of female subjects. Therefore, certain aspects of female embodiment have been medicalised, such as pregnancy and menstruation, through, for instance, surgical interventions (Dally, 1991). Feminist work in this area has further developed insights from the sociology of health and illness and the sociology of scientific knowledge to critique the ways in which ideologies inform medical practice (Fox, 1989; Jacobus, Keller and Shuttleworth, 1990), as well as the social basis of the development of scientific thought and knowledge (Rose, 1987). These claims point to variability in expert understandings of the female body and the historically constructed nature of representations of the female body. They draw our attention to the ways in which femininity has been marked out in feminist discourse, and reified, as explicitly embodied, in contrast to implicitly disembodied masculinity. This assumption obscures the observation that the male body too, is regulated in specified ways, according to the demands of waged labour and capitalist time (see for instance, Morgan, 1993). The female subject has been addressed by feminism as an *embodied* subject, yet, it has been done so in ways which throw the ambiguous status of embodiment into relief.

The Ambiguous Status of Female Embodiment

Health Activism and Embodied Experience

Attention to embodied experience has been of particular concern for second wave feminist critique in general and for the women's health movement in particular. This form of critique has developed in a number of ways. First, feminism challenged the way in which health was defined

in the language of biomedicine and argued that the female body is a target for medical intervention, as a means of sustaining and reproducing patriarchy. Hence activism focused on the embodied experience of health care. Second, feminism addressed issues of access and inequality within the organisation and delivery of health care. Third, feminism revealed the ways in which social life obscured the specificities of female embodiment. In much of this critique, female embodiment occupies an ambiguous position.

Ehrenreich and English (1974), for instance, emphasise the paradox of female embodiment, open to redefinition within medical culture as socially prohibitive. They argue:

'Say that menstruation is painful and distressing, and women will be arbitrarily barred from occupations that involve concentration and responsibility. Say that it is unnoticeable and that we are as consistently healthy as males are supposed to be, and all women will be required to lift the same weights and work the same long hours required of men regardless of the degree of discomfort experienced. Say that the last months of pregnancy are difficult, and we will be fired at the first signs of swelling. Say that there is 'nothing unhealthy about being pregnant', and we will be held to eight hours a day, five days a week. There are real dangers — for all of us — in either underestimating or exaggerating our needs as women.' (1974, p88)

The female body, as a leaky, messy, bloody body, is expressed here as paradox. It is identified as a potential barrier to social membership for women in ways which have underpinned debates on the exclusion of women from the public sphere (see Pateman, 1989). It is therefore noted as a body in 'trouble',³ in ways which reveal both the implications for the denial of a specific form of embodiment and for the redefinition of embodiment in ways which might transform social and political life. This ambiguous status is best illustrated through examples drawn from feminist documentation of reproductive health.

³ I draw here upon a forthcoming paper by Hughes and Witz (1996) which plays on the notion of 'trouble' in relation to the female body, in order to stage a critical discussion of how both Simone de Beauvoir and Judith Butler address the relationship between the body and gender.

The history of the women's health movement in the West has often been written as a triumphant history. It is seen as a movement in response to medical power and control over aspects of female embodiment, through which many women found ways of raising critical voices to the organisation and delivery of health care in general and reproductive care in particular (Lewin and Olesen, 1985). In the 1960s, issues of reproductive control through access to abortion and contraception were of particular concern in Western societies. For instance, women formed clinics in order to enable women to gain access to abortion and contraceptive services and knowledge.

The raising of critical voices in North America spawned body consciousness raising and ways of producing alternative knowledges of the female body (Ruzek, 1978). Self-help, in particular, was a means of appropriating medical knowledge as a way of 'learning the language of the professional' (Ehrenreich and English, 1979) in order to enhance personal autonomy and create the potential for empowerment. The Boston Women's Health Book Collective and the publication *Our Bodies Ourselves* (Phillips and Rakussen, 1971), is a classic illustration of this approach, as indeed, in Britain, was the proliferation of radical critique and sources of information, such as *Spare Rib*. Both feminist health education and later, promotion, became an important challenge to the medical model of health care producing written materials and information for women through myriad national and local groups such as the *Women's Health Information Network* in England and the *Cervical Smear Campaign* in Scotland. These groups and materials were perceived at the time as radical strategies for challenging medical knowledge and developing alternative sources of information and knowledge bases for women.

Feminist critique addressed the ways in which health was defined within the medical model. Nurses played a large role in challenges to the medical model as a way of responding to the female body and women's health, developing critiques of the medical model around the notion of 'health care for women, by women' (Lewin and Olesen, 1985). The identification of healthy women as 'patients' was problematised and spawned practices such as 'well woman clinics' to provide services such as breast and cervical screening (Gardner, 1982). In Britain well women clinics and the

concept of 'women's health' began to enter not only academic critiques of medicine, but also clinical practice itself.

However, there is significant debate within feminism around the particular identities which are associated with the 'well woman'. For instance, Wilkinson and Kitzinger (1994) argue that the identity of 'well woman' introduces a route for increased victim blaming in which women themselves become ever more responsible for the production of their own health. Nevertheless, the development of a 'well woman' critique and the pursuit of health promotion was perceived by some feminist activists as an empowering and enabling way of challenging the medical model, and one which would be sensitive to the diversity of experiences and choices with which women were faced (Hastie, Porch and Brown, 1995). Health promotion could thus be read as producing a different kind of health, through which 'empowerment' is the rubric under which internal change is produced. Chapter Four will pick up the issue of empowerment and its relationship to responsibility and personal choice in the context of prevention.

Feminists in sociology have also developed the argument that a biomedical approach to the body objectifies and idealises the female body as 'Other'. The biomedical paradigm is seen to entail compartmentalization, segmentation and fragmentation (Oakley, 1984; Stacey, 1988; Martin, 1989). Pregnancy and childbirth in particular, have been subject to medical scrutiny in ways which pull it further into a relationship in which medical culture exerts a significant degree of control over the experience of pregnancy and childbirth. The medicalisation of pregnancy and childbirth was identified by feminist sociologists, who argued that medical culture framed these experiences as a medical event (Graham and Oakley, 1981), and reinforced it as such through the deployment of technologies such as ultrasound (Oakley, 1993). As Stacey (1988) has observed, the objectification of the female body has implications for clinical practice and for women's experience. In childbirth, for instance, ultrasound has become a crucial tool of confirmation, one through which women may legitimately 'know' they are actually pregnant. What the reliance on technological and visual representations of pregnancy does for women is to transform the terms of their embodiment by placing emphasis on the

visualisation of the foetus as confirmation of pregnancy (Petchesky, 1987).

Similarly, ante-natal screening practices such as chorionic villi sampling, or amniocentesis, are more recent examples of the way in which technological interventions at an early stage in pregnancy potentially transform pregnancy in to a medicalised experience. *Pre-conceptive* care has become accepted practice within primary care, as women are given advice on dietary intake and vitamin preparation prior to conception (Lupton, 1994). Such care raises issues of body boundaries and feeds into both debates about foetal protection, for example, in relation to smoking during pregnancy (Tsing, 1990) and suggests that the boundaries between the female body and medical culture are being redrawn, as medical culture defines the embodied experiences of reproduction earlier and earlier (see also for instance Rowland, 1992).

Technological innovations have been visited by feminists in sociology as undercutting the validity of embodied experience and knowledge in ways which redefine embodiment as a secondary form of knowledge. Consequently, many challenges to medical knowledge and practice in relation to pregnancy and childbirth, were staged in ways which emphasised the specificity and authenticity of female embodiment. Campaigns such as *Active Childbirth*, sought to reshape the choices and possibilities in which women might experience pregnancy and childbirth. The *Natural Childbirth* movement similarly challenged the disempowering experience of medically organised pregnancy and insisted on the rights of women to be listened to and included as active participants in the birth process (Arney, 1982). It is worth noting, however, that this kind of response mobilised notions of authenticity and promoted choice in ways which potentially reinforce an essentialist framework in which to locate female embodiment.

The emergence of body consciousness, the redefinition of health and radical texts, placed particular emphasis on the notion of empowerment and self-knowledge as the means to challenge medical culture and transcend medical power over the female body. The following passage from Sheryl Ruzek's history of self-help illustrates the priority placed on

empowerment in the genesis of the women's health movement and self-help:

'The "invention" of self-help gynaecology more than any other event transformed health and body issues into a separate movement. Self-help gynaecology was born on April 7, 1971, at the Everywoman's Bookstore in Los Angeles. For some time, feminists had met there to discuss health and abortion issues. After exhausting "book learning", Carol Downer, a member of the group, urged empirical observation. That evening, Downer inserted a speculum into her vagina and invited the other women present to observe her cervix." (Ruzek, 1978, p53)

Here, women are positioned as users of a health care system which fails to deliver according to their needs, and which, furthermore, claims knowledge ownership of the female body. Significantly, the statement also illustrates a tension between the identification of female subjects as 'service users', such as that provided within a political economy approach, and the female subject as a medicalised subject. The patriarchal nature of medical culture and the delivery of health was the initial target for feminist activism and academic feminism. The emphasis in this extract is on *reclaiming* the authenticity of embodied experience, in order to redefine health as the core concept around which care is organised and delivered.

Whilst the zenith of the women's health movement in North America was never quite matched in Britain, symbolised, for instance, by cervical self-examination groups, nevertheless, the construction of knowledge about the female body was seen as a key way of improving women's confidence and validating their embodied experiences (Doyal, 1983, p22; Hastie, Porch and Brown, 1995). Feminist redefinitions of health handled embodiment as a source of empowerment and transcendence, rather than as a barrier to social and political participation.

A second emphasis within feminism was towards issues of access to health, inequalities and the organisation of health care (Doyal, 1983). These issues crystallised around a gendered division of labour in the production and maintenance and health. This phase of health activism made the sexual division of labour within health care more visible and highlighted

the ways in which women did paid and unpaid in the production and reproduction of healthy bodies and minds (Stacey, 1988). Activism focused on women as providers and users of health care, with the establishment of *ad hoc* political groups which represented a spectrum of interests across formal health care workers, such as the *Radical Midwives*, *Radical Nurses*, *Women in Medicine*. Groups such as these, as well as female participation in trade unions representing health care workers, struggled to defend health care cuts and defend the NHS against privatisation in the early Thatcher years (Salvage, 1985). Women in both North America and Britain were identified as the major users of health care (Verbrugge, 1985; Doyal and Pennell, 1979; Stacey, 1977); as the major producers of health care in the public domain, both formally and informally (Gamarnikow, 1978); and as the major providers of informal health care in the private sphere (Finch and Groves, 1983).

Women, therefore, have been directly and adversely affected by the political ideology associated with Thatcherism and New Right politics and policies over the 1980s (Lister, 1990). This approach can be revisited as an acknowledgement of the specific embodiment of care in both public and private space. Within this kind of argument about feminised health care, feminists associate female embodiment with the care of other bodies, both through waged work and informal care. As a challenge to medicalised models of health care, knowledge and practice, feminism has also located the female subject as one charged with care of the self and her own body. Therefore this position also reinforces embodiment as central to female experience in relation to issues of care and self-care.

The third emphasis for feminism was the way in which social life obscures the specificities of female embodiment and the processes which make women sick (Doyal, 1983, p21). This emphasis identified a more general division of labour which took into account the social position of women and their location between and across worlds of paid and unpaid work. Particular conditions, such as menstruation and menopause, bridge these worlds and have come under sustained feminist scrutiny in ways which have drawn attention to the ambiguities of female embodiment. Concepts of pollution and taboo have been important in the construction of menstrual blood as 'matter out of place' (Douglas, 1966) and some feminists



have further identified historical links between anxieties about contamination and pollution from menstrual blood, for instance, within biblical discourse and the segregation of menstruating women, and contemporary contamination anxieties expressed in the sanitising language of advertising (Laws, 1990). These kinds of anxieties find expression in the ways that women are implicitly encouraged to adopt concealment strategies in their management of menstruation (George and Murcott, 1992). Concealment is also dominant within the advertising of 'feminine hygiene products' or 'sanitary products' (Treneman, 1988).

Laws (1990) locates both the concealment of menstruation and medical knowledge about menstruating women more generally in masculine ideas which position female embodiment as a deviation from a male norm. Menstruation is understood within medical knowledge as a biological deviation and it is this deviation which provides the basis for regulation and intervention. Hormonal treatment and the surgical practice of dilation and curettage, for instance, are two mechanisms through which menstruation is brought under medical scrutiny. Laws uses this insight to illustrate how the creation of new medical categories in relation to embodied experience should be seen as a strategy through which the female body is constructed as a deviant body. This strategy finds its clearest expression in the notion of *pre-menstrual syndrome* (PMS), a conceptual umbrella under which a variety of embodied experiences are addressed within gynaecology and general practice (Rodin, 1992). The implication of this approach is that the authenticity of female embodiment is subsumed beneath incongruous - masculinist - ideas about the female body.

Rodin (1992) has argued that there are historical continuities between current models of PMS and nineteenth century ideas about hysteria. Within the latter, legal and medical discourse was used to highlight the irrationality and lack of control embodied by the hysterical woman. As a diagnostic category in the twentieth century which focuses on hormonal imbalance, PMS embodies ideas about femininity and the female body and reflects views about women's place in society as carers and servicers. Just as marriage was a 'remedy' for hysteria in the nineteenth century, emphasis on hormonal imbalance in the twentieth century, and therefore,

implicitly, 'unpredictability', is sometimes drawn upon to legitimate claims that women ought not to be given positions of responsibility in the public sphere (Rodin, 1992). However, this line of argument has also been used by feminists to draw attention to embodied difference. For instance, 'diminished responsibility' has increasingly been deployed within legal discourse as a defence for women charged with crimes of violence (Atkins and Hoggett, 1984). Feminist reliance on the category of PMS, in many ways reinforces ideas about the female 'at the mercy of her hormones' and therefore reproduces essentialism in addressing female embodiment.

In contrast to medical and feminist discourses which have supported understandings of PMS in essentialist terms, feminist anthropologists have suggested that PMS should be seen as a 'symbolic safety valve' (Johnson, 1987) through which women give expression to the social contradictions inherent in expectations around production and reproduction. This view emphasises both the material ways in which women experience bodily disruptions in ways which make it difficult to carry on the dual and diverse burdens carried by women in the Western world. Riessman (1992) argues that women participate in the construction of medical categories, such as PMS, as a way of finding solutions to embodied experiences which pose disruptions to their lives. Here the 'medicalisation' of PMS, through the construction of medical categories and the shaping of interventions such as surgery and hormone therapy, has also provided a mechanism through which women have been able to find legitimisation and authoritative support for such disruption. This approach shifts analysis away from both arguments about social control, and the way in which women are placed as victims within them, and away from a strong version of constructionism, in which embodied experience is held as the authentic counter to medical knowledge.

Embodiment, Empowerment and Authenticity

The initial focus of the second-wave of feminism was clearly on the 'politics of the body' as Bordo (1993) has observed, in the sense that what women do to the surfaces of their bodies, and have done to spaces within their bodies, has implications for the ways in which women come to experience social membership. Feminist work thus sought to expose the social processes through which the female body was placed in an uneasy

relationship with society, and to attempt to liberate it through both denial of its specificities and embrace of them. Yet in doing so, tensions and dualisms have been reproduced, between the body as a universal category and embodied experience, as a particular category. Arguments around medicalisation, social control and construction, either deny the significance of embodiment or embrace embodiment as a source of authenticity and as a means of empowerment.

Medicalisation has been a key concept with which to address a female body which is variously denied and embraced. Furthermore, this concept depends upon a hierarchical model of power relations, or a strong version of patriarchy. This is illustrated in the language of colonisation through which medicalisation has been expressed. Yet it is a problematic model of relations, since, however patriarchy is defined, there have been significant shifts in the latter part of the twentieth century which point to the inappropriateness of a strong version of patriarchy. Such a model is unable to address the presence of conflict within medical culture in the development of knowledge and practice. Furthermore, it is unable to address the ways in which embodied subjects use the effects of medicalisation as a strategy to legitimise those embodied experiences which were previously not held as legitimate in the social sphere. In short, medical culture needs to be acknowledged as a form of power which produces effects with which women interact and use productively.

Debates on social participation and citizenship place emphasis on the female body as an emancipated body, in contrast to a body chained to biology, as destiny. The critiques of medical knowledge and practice which this position produced emphasised the ways in which medical understandings of female embodiment, health and illness were socially constructed. Hysteria was, for instance, redefined within feminist discourse as a political device through which medical and legal discourse sought to exclude women from professional participation.

Whilst the rejection of biology has been an important political tool of early second-wave feminism (de Beauvoir, 1972), it also contains within it, allusions to the 'truth' or authenticity of female embodiment as an essentially troubled body (Hughes and Witz, 1996). However, debates

around women's health have redefined such trouble as a *source* of female empowerment by drawing attention to the ways in which the denial of embodiment is embedded within medical culture. Empowerment has been posed as a strategy of political resistance in this discussion, particularly from within radical feminism (see for instance, Daly, 1978) in ways which reinforced the significance of the specificities of female embodiment. Menstruation, pregnancy, childbirth and breastfeeding began to be seen as unique embodied experiences which might also redefine the importance of the relationship of body to self and vice versa (Ruzek, 1978). The reclamation of the female body and its unique experiences grounded the redefinition of the relationship of women to their bodies, and was underpinned by the emergence of body consciousness courses and groups; the resurgence of 'traditional' female healing techniques; and the emergence of 'well woman' clinics.

These gender specific moments can also be located within a broader project associated with modernity, in terms of 'knowing' one's own body and one's own self (for instance, see Lasch, 1980), which underpinned a cultural politics which invests power in the feminine through sexual difference (Daly, 1978) and uses this to argue for the special status and contribution of women to the social body (MacKinnon, 1987). Indeed, the shift towards self knowledge and body knowledge as an aspect of feminism, reflects a more general desire for foundationalism, or a more solid basis for self (Freund, 1988). Yet, as Ruzek (1978) also points out, the redefinition and celebration of the female body which this engendered, reinforced the importance of reproduction as the core of femininity.

Feminists have argued that the female body has been shaped as an object of scrutiny for science and medicine in ways which have allowed political action to deny the significance of female embodiment. On the one hand, the female body has been identified as a target for expert power, socially *controlled* through medical practices, the formation of medical knowledges and the ideologies which underpin medical culture. Here, the specificities of female embodied experience are held problematically within relations of power which make liberation a political necessity, as we might see in Laws (1990) discussion of menstruation. Simultaneously however, the female body has been identified as a body which is socially

constructed through practices, knowledges and ideologies, but in ways which serve the broader interests of capitalism or patriarchy. The case of *premenstrual syndrome* illustrates this position. Such analysis views the female body as subject to the jurisdiction of sovereign power, as displayed within medical culture.

Feminist discourse has perceived the female body as a medicalised, and therefore disempowered body, through the construction of expert pathologies which deny the authenticity of embodied experience. Female experience has been understood as embodied experience, for instance through the regulation of reproduction and the symbolic meanings attached to it (Lawler, 1991); through the management of menstruation (Laws, 1990) or menopause (Lewis, 1993). Feminism, whilst not explicitly foregrounding embodiment in early critiques of practices and knowledges which claimed the body as its site of power, has nevertheless emphasised the importance of embodied experience. Central to the development of feminist critique has been the troubled relationship between mind and body. However, whilst feminism has critically addressed dichotomous thinking within general theory, in sociology and elsewhere, it has done so in terms which produce ambiguities.

Debates about the status of the female body in relation to the construction of difference have generated an over-emphasis on embodied experience and analysis of the female body, as though each were separate entities. The specificity of the female body is mobilised in *opposition* to the male body and simultaneously, the universality of the female body is mobilised in *relation* to other female bodies. Embodied experience is deployed as a final arbiter of self, through its corporeality and materiality. Female subjects are seen to appeal to embodied experience as a means of resisting the categories and definitions which experts are seen to impose on women. Embodied experience, as subjugated knowledge, is deployed within feminist discourse as a political strategy with which to resist abstract theorising around the female body. Yet it raises the issue of authenticity and forces us to question what it is to which feminists and/or women appeal when they speak of embodied experience.

Embodiment, Feminism and Sociological Theory

Gendered Embodiment

'...embodiment [is] a cultural process by which the physical body becomes a site of culturally ascribed and disputed meanings, experiences, feelings.' (Stanley and Wise, 1993, p196)

Bordo (1993) observes that early feminist theory can be seen as embodied theory, although it may have not proclaimed itself as such through its concern for political drive and clarity. It is true that feminism has been concerned with embodied experience and its implications for social membership and feminist argument has to a large degree been discharged through the female body. It has not been the case, however, until relatively recently, that *embodiment* has been the core concept addressed within feminist theory and research practice (Morgan and Scott, 1993), but rather, the relationships between the female body, the demands of femininity and the maternal role, and patriarchal oppression (Potts and Price, 1995).

Feminists have also been concerned with the potential slide from embodied experience and an attention to materiality, to physicality, to corporeality, into essentialism and anatomical rigidity (Potts and Price, 1995). The central problem in this debate is the need for clarification between a pre-social body, which hints at subjugated authenticity, onto which cultural ideas and social meanings are inscribed, positioned against a discursively produced body which reduces material to immateriality and therefore denies any significance for embodiment. Feminist discussion of female embodiment has most recently been channelled through post-structuralism and in particular, 'new French feminism'. Much of this work addresses the relationship between the female body, female subjectivity and power with a view to developing arguments about female embodiment which avoid essentialism, by identifying an 'imaginary body' (Irigaray, 1986). In this work, the female body is not understood in essentialist terms, but nevertheless, the diversity associated with female embodiment is essentialised. In the work of (Irigaray, 1986) and Wittig (1981) for instance, the 'body vanishes into the self and interior is privileged over exterior' (Marshall, 1996, p254).

Embodiment therefore occupies an unresolved status in feminist discussion which addresses the relation of the body to experience and what female subjects appeal to in the articulation of experience. Emphasis on embodied experience and the female body is characterised by conceptual slippage. This is politically problematic, as we have seen, but is analytically problematic because such slippage confuses different things: the body as a social construct and a set of ideas; embodied experience as subjective experience; embodiment as a concept with which to capture the interaction between these two. The notion of embodied experience is problematic because of the way in which it always mediated through discourse, ideas, practices. Sociologists (Morgan and Scott, 1993; Zola, 1991) have argued for the central placement of embodiment within work on gendered embodied experience, and reciprocally, the necessity of using work on gender to explore the sociology of the body. Female embodiment, as anthropologist Martin (1990) has so clearly established, is understood and articulated through a variety of different social and cultural categories.

Martin's work on pregnancy and childbirth suggests that whilst the management of female embodiment is a common thread of experience for many women, the emphasis and priorities placed on such management varies culturally and historically (for a recent development of this argument see Marshall, 1996). Such a perspective points to the difficulties of raising embodied experience as a critique in itself of medicalised approaches to reproduction, since embodied experience is shaped and understood culturally. Bodies have been differentially constructed across historical time and space. Hence conceptual distinctions are required between the female body as a universal category and the historical and cultural contexts through which it is transformed into experience. Other anthropologists (Scheper-Hughes and Lock, 1987) make similar distinctions between different levels of understanding about the body. From within feminist philosophy, Butler (1993) argues for materiality which avoids essentialism, embodied subjectivity which is both object and effect of discourse, and for theorising as an embodied act (Potts and Price, 1995).

Martin's analysis provides a starting point from which to think about embodiment, in contrast to the female body or, indeed, embodied experience. The notion of 'thinking through the body' (Caddick, 1986), or of perceiving embodiment as a means of interpretation returns us to the project of general theory. In Chapter One I argued that this project has recently been concerned with 'bringing the body in' and that Foucault should be seen as a means of achieving this incorporation. Foucault has also been drawn upon within feminism to explore power, the analysis of resistance by those on whom such power is enacted, and indeed by those associated with the mode and means of power.

A solution, therefore, to the tension between the reification of embodied femininity on the one hand, and the ambiguous status of female embodiment on the other, is to adopt a critical position in which the significance and nature of embodiment is never fixed. Such a position would capture the extent to which people do appeal to embodied experience as a means of interpretation, and at the same time, reveal the various ways in which body and self interact and interconnect. Of particular importance for feminism, is the gendering of embodiment and issues of power. The task for feminism is to demonstrate the ways in which the body, embodiment and subjectivity interact and set 'truth' in place, and to demonstrate the particular ways and contexts in which such tensions operate. Therefore I now revisit the significance of Foucault for developing the conceptual utility of embodiment.

Revisiting Foucault

'Nothing in man - not even his body - is sufficiently able to serve as a basis for self-recognition or for understanding other men.' (sic) (Foucault, 1990, p152)

Foucault offers a caution here to those who appeal to the body as authenticity and warns against thinking of the body as the basis of self. For Foucault, the body is socially and historically produced through the effects of power and it is this approach which has been especially seductive for feminism. Feminist debate has begun to rethink hierarchical concepts of power. Critiques of the oppositions of Marxism to liberalism have embraced 'deconstructive' (Gatens, 1992), 'post-structuralist' (Irigaray, 1985) and Foucauldian frameworks (Bordo, 1989),

for instance, by incorporating analysis of resistance to the theoretical handling of substantive areas (Bordo, 1990; Holland, Ramazanoglu, Sharp and Thomson, 1994). Here we find a more explicit statement of gendered embodiment and the nature of the link between the body and gender. Foucault's observation that analyses of power need to concern themselves with materiality and the local production of knowledge, (Foucault, in Gordon, 1980), has been critical to this concern.

Nevertheless, Foucault did not address the gendered nature of embodied experience, therefore, feminist engagement with his work has produced a variety of responses from within feminism (Bell, 1993). Many feminists have rejected Foucault because of the failure to acknowledge the specificity of female embodiment and of the apparent reduction of power to discourse, in ways which undercut a sense of universal domination (see Evans, 1993 for a critique; Harstock, 1990). Strategic rejection of Foucault is premised on what many feminists have seen as the political necessity to retain a sense of the common oppression of women (see Walby, 1992, for example). This view has been well critiqued elsewhere (Flax, 1990).

If the first response from feminism has been rejection of Foucault, the second has acknowledged the potentiality for the concept of 'disciplinary power' as a way of demonstrating the specifically differentiated ways in which female bodies are marked out and empowered to perform particular kinds of task (Gatens, 1992). This position has developed through largely theoretical and philosophical writings to address the complexity of power's operations; the exercise rather than the possession of power and the contingent rather than static nature of power. Grosz (1994) for instance, offers the notion of 'corporeal feminism' as a means of integrating 'lived experience' and its production and interaction with cultural categories. She argues that the body can be understood as:

'the site of the intermingling of mind and culture; it can also be seen as the symptom and mode of expression and communication of a hidden interior or depth.' (1994, p116)

As can be seen from my discussion in Chapter One, this position, although stemming from feminist philosophy, has parallels to the kind of position set out by sociologists such as Shilling (1993), who poses embodiment as a

dialectic. However, the position of Grosz and other feminist philosophers, draws more heavily on Nietzsche and Foucault. In particular, the notion of 'disciplinary power' is important in this work and has been used within feminism in two key substantive areas, in an attempt to build in an analysis of resistance. First, Bordo (1989; 1990) has argued that eating and menstrual disorders amongst women in the late nineteenth century and the twentieth century, from hysteria to bulaemia, are embodied responses to social closure and the ways in which society forces women to nurture others at the expense of themselves. The female body is seen as disciplined, as a means of regulating femininity, and analysis places emphasis on 'practices of femininity' (Bartky, 1988), through what women do, in the construction of female subjects.

Second, in a series of papers addressing young women's sexuality and negotiation of sexual encounters in the context of AIDS and sex education discourse, Holland and her colleagues (for instance, 1990; 1992; 1994) have developed a post-Foucauldian model for the exploration of power, pleasure, risk and trust. This model attempts to incorporate not only the relations, powers and forces which shape particular experiences and the articulation of experience (Smith, 1989), but also explores the ways in which young women interpret their interaction with those relations. Such an approach more than hints at conceptual distinctions and interactions between the body, embodied experience and embodiment. For instance, feminists have demonstrated the problems associated with dualist assumptions, and how they obscure the extent to which women may live a disembodied femininity, yet lack a consciousness of it (Holland, Ramazanoglu, Sharpe and Thomson, 1992).

Post-Foucauldian feminist critique utilises the relational character of power/resistance and the way in which power is conceptualised as 'the multiplicity of points of resistance within strategic power networks' (Foucault, 1990, p95). Furthermore, whilst the body in early Foucault has been perceived and developed as a docile body (see Bordo, 1990), in later Foucault, the female body is developed as the effects of power, discursively produced through practices of self (Deveux, 1994). This development has emerged from an unresolved tension between surveillance and self-surveillance, or regulatory and disciplinary power, and the different

forms of power which they imply. Foucault's later work, for instance, in *The Care of Self* (1986) begins to acknowledge this conceptual problem and reintroduces agency and reflexivity. McNay (1992) has argued that Foucault reworks Enlightenment categories through the development of a theory of practices of self. Whilst Foucault rejected the possibility of universal claims to truth, his work has been drawn upon to examine how individuals actively define identities through bodily practices which are themselves defined by the social context in which they occur. McNay argues that rather than being positioned in opposition to the Enlightenment, later Foucault is more closely linked to the Enlightenment, since practices of self imply a degree of reflexivity and individual critical thought missing from his earlier work. Feminists have drawn upon this insight in order to illustrate how emphasis on the body and the relations of power allow us to consider *how* discourses and practices create subjects; how they construct certain kinds of body with particular powers and capacities, how bodies are relate to their subjects (McNay, 1992; Sawicki, 1991; Gatens, 1992).

This opens up potential for analysis of both process and experience and hints at interaction between embodied experience and the female body, by focusing on the dispersed nature of power and the ways in which 'tactics' may operate towards different objectives. The emphasis here is on 'biopower', which is understood as an historically new form of regulation over life (Hewitt, 1983). However, feminist debates have not, by and large, explicitly addressed a sociological community in their discussion of gender, power and the body. My approach has been to relate these debates to sociological concerns and therefore, in what follows I revisit the concerns to which I drew attention in Chapter One through the discussions of both Foucault and feminism developed in this chapter.

Sociology, the Body and Surveillance - an Emerging Feminist Critique

Sociological theory has begun to address the problem of 'bringing the body in' but has done so in ways which separate analysis of the body from analysis of embodiment. My discussion of general theory in Chapter One, highlighted how sociological theory has attempted to incorporate the body but has failed to allow this incorporation to reshape the discipline or the categories of general theory. At the same time, sociologists have borrowed

from Foucault and feminism in order to address the body and power, particularly in relation to issues of regulation and surveillance. This work has developed common analytic features: practices produce knowledges; discourses produce objects of examination; individuals are placed as knowing subjects. However, I have argued that there are problems associated with this work, linked to the failure of Foucault, and the reproduction of this failure in sociological work, to resolve tensions between his use of surveillance and self-surveillance. The conceptual problems I have identified in this work are associated with the over-reliance on regulatory power and the under-development of the concept of disciplinary power.

First, this work has a tendency to make claims about the relation between surveillance as a new form of social regulation and the creation of new identities, on the basis of observations made about *practices* of surveillance. Such work focuses on regulatory forms of power at the expense of disciplinary forms of power, despite claims to the contrary. Claims about the connections between the discursive creation of norms, the deployment of power/knowledge and individuals' incorporation of them into their own thoughts and activities are made on the basis of observations about the application of medical knowledge and practice, not the experience of such application. Hence the power addressed in Chapter One, is observed from the perspective of how it is installed, rather than from the standpoint of those who are subject to power (for a more general criticism of Foucault in this respect, see McNay, 1992, p134). Consequently, there is a pressing need, which Nettleton's work begins to address, to locate the embodied subject at the centre of enquiry.

Second, Foucauldian work claims to be able to identify resistance to power/knowledge in medical culture. Indeed, the utility of disciplinary power as a concept, is in identifying the minute areas in which power is located, or its 'points of application', whatever subjects individuals to dependence, control and ties the individual to her own identity through the development of self-knowledge. It is at these points analysis will discover 'multiple resistances'. However, the 'multiple resistances', which the authors I have cited claim power produces, are often obscured, and what is analytically available is an endless conformity to norms. This both

over-emphasises professional power and obscures the significance of embodiment. In contrast, in order to identify not only the new subjectivities which such work claims to reveal, but also the diversity and complexity of such subjectivities, a methodological shift in focus *toward* embodied subjectivity, or embodiment, is required. As sociologists of the body have moved towards Foucault and a constructed body it has been forced to confront feminism as a statement of variable embodiment.

Feminism has focused, both implicitly and explicitly, on the female body and embodied experience. The female body has been a focal point for feminist politics and theory as either dystopian, as the source of pain and conflict, or as the source of imagined utopia, through reclamation and reinscription.⁴ The publication of *Our Bodies Ourselves* makes an essential connection between the corporeal and the existential, through the claim that whatever is done to bodies has a political dimension. Much of this work mobilises *embodied experience*, but I have been arguing that more recently, feminist discussion has begun to utilise the notion of *embodiment*. Embodied experience, in a sense, is always mediated through speech, text, and other observations which claim an 'objective' standpoint, such as heart monitors or cervical smears. Our understanding and knowledge of the body rests on the gauges we deploy to measure and penetrate its depths. Our individual embodied experience can only be represented in measures other than the experiences themselves, hence there will always be a disjunction between experience and representation of it.

This is not to argue that the body stands, alone, as a final arbiter of truth in the face of postmodernity. The task for sociology, is rather, to demonstrate the ways in which the truths of the body come into being, and the relations of power in which they are held. As Dorothy Smith (1989) says:

'Designing a sociology for a knower situated in the everyday/everynight world of her actual lived experience means proceeding differently from the standard practice of sociology. It means, among other things, turning the

⁴ There is an extensive range of feminist fiction, particularly science fiction, which utilises female embodiment both as dystopian (for instance, Piercy, 1979) and utopian (for instance, Atwood, 1986).

established enterprise on its head: Rather than explaining how and why people act (or behave) as they do, we would seek from particular experience situated within the matrix of the everyday/everynight world to explore and display the relations, powers and forces that organize and shape it.' (p34)

To this we might add embodiment as a concept which expresses the body as both a condition and constituent of action and interaction. Within this perspective, then, the *body* ceases to preoccupy sociological theory, and embodiment becomes a prism through which to examine the social world. Embodiment becomes the conceptual framework through which empirical observations are made, and sociological analysis derived. Such a manoeuvre makes more possible an approach through which gender is made an explicit focus for analysis, by examining the processes and mechanisms through which female materiality manifests itself. The link between the body and gender, in this approach, is therefore, not reified and embodiment potentially reshapes the sociological project. I now introduce a substantive issue through which to develop this undertaking, in Section Two.

SECTION TWO

In Section One I presented theoretical debates around the body and surveillance; gender and embodiment and located these debates within an analytical shift from general theory to particular experiences, and from universal knowledge to local knowledges. In Section Two, I develop this shift in relation to the substantive issue of cervical screening. Cervical screening is upheld by a rhetorical power which obscures uncertainties and inadequacies in practice and experience. On the one hand screening is located within a framework of individual choice, which stems from both consumerist rhetoric and feminist emphasis on empowerment. On the other hand, in an attempt to secure higher levels of participation, the nature of choice has shifted through the introduction of targets and quotas within general practice, through which the delivery of screening is now regulated.

Consequently, there is a tension between the liberal language of information and choice and an authoritarian framework, in which population monitoring is emphasised, but which relies on the market in order to regulate professional practice. Indeed, the basis of this relationship is now initiated by practitioners who invite individuals to participate in prevention programmes, and in turn, are themselves subject to scrutiny by the state. Furthermore, cervical screening is also located within the context of shifts in the client/professional relationship, in which individuals are increasingly encouraged to question and challenge medical knowledge, yet, at the same time, expected to comply with invitations to participate in screening. Hence both the status of knowledge and the nature of the relationship between clients and professionals is under redefinition.

It is within this context that social science research has addressed cervical screening as a taken for granted instance of prevention. This work has been characterised by tacit acceptance that such intervention is necessary for the detection of disease, as part of the project of public health and its concerns with establishing universal betterment. For policy makers and health promoters, early detection of pre-cancerous cells continues to be an important strategy in the prevention of cervical

cancer. Consequently, research agendas have focused on the identification of reasons and causes for *non-participation* in preventive regimes, such as screening, and indeed, have contributed to the normalisation of such participation.

In this Section, I develop these arguments along two interlocking axes. First, Chapter Three traces a discursive transformation within medical culture, from diagnostic testing and disease detection to community prevention. Prevention is the critical discourse through which cervical screening is understood, yet it has been constituted as such across different contexts. In this chapter, I identify observations which have contributed to the production of knowledge around the cervix, and of screening. I draw on textual data derived from medical journals and published documents which address issues of cervical smear interpretation and classification, and the identification of screening subjects. In particular, I focus on the agents of observation: professional debates around the meaning of cervical smears and the language which is used to describe and represent this meaning. I use this material in two main ways: first to illustrate the creative processes through which the project of cervical screening has been engendered, and second, to develop an argument about surveillance and its emergent relationship to risk.

The second axis along which Section Two develops is in relation to current social science approaches to cervical screening, and the critical concerns therein. Chapter Four outlines these approaches, which have largely engaged in a project of knowledge acquisition for the purpose of policy formation and implementation. With few exceptions, this work has focused on women's attitudes to and knowledge of cervical screening. Furthermore, in presenting cervical screening as a form of prevention, this work has seldom addressed the experience of abnormal or positive smears, and the interpretation of such an event by those women who experience it, except to point up women's knowledge deficiencies, or to identify areas for improvement in relation to issues of access.

CHAPTER THREE

FROM DIAGNOSIS TO PREVENTION

Diagnostic Testing and Prevention

Introduction

Before I introduce empirical data on the experience of cervical screening in Section Three, I wish to highlight the relationship between surveillance, prevention and diagnostic testing. In this chapter, I present textual material drawn from public debates in medical journals which I use to draw a conceptual distinction between diagnostic testing and prevention, although both emerge from similar imperatives and demonstrate the shift in medical culture from acute to chronic conditions in the twentieth century. The material I present here suggests that we should see the emergence of prevention as an expression of surveillance. However, this should be viewed as a contingent process, rather than a dominant value driving the pursuit of diagnostic test refinement. One implication of this is that risk, therefore, should be seen as a *product* of surveillance, rather than as the basis of its expansion.

As outlined in Section One, sociological interest in surveillance has developed through studies of public health and prevention. In this work, health is understood as an imperative of modernity (Lupton, 1995) underpinning the emergence of surveillance as a new form of social regulation. In turn, surveillance, as a new governing medical framework (Armstrong, 1995) has emerged in the context of struggles around the status of expert knowledge and professional development (Arney, 1982). For example, the need to define public health as distinct from general practice created a space in which social medicine emerged, premised on diagnostic testing, which involved the examination of healthy populations (Armstrong, 1993).

With regard to this latter development, the boundaries between normal and abnormal have become increasingly precarious in ways which have opened up potential for disease detection (de Swaan, 1990) or 'detecting the undetectable' (Stone, 1986). This opening up of disease potential has been shaped into prevention. Screening programmes in the twentieth century illustrate the relationship between the perception of disease potential and

prevention. Screening for tuberculosis, child immunisation, blood pressure and cervical cancer, demonstrate the extent to which systematic and periodic 'check-ups' have become a routine experience in which many individuals come into medical view, defined as 'potentially at risk' (Armstrong, 1995).

The prevention of disease is therefore a strong theme in the collective management of health in the twentieth century. The development of a welfare model of citizenship in Britain was entrenched in the emergence of a National Health Service, through which the state would provide and guarantee social rights in relation to health. This development also entailed a transformation of public health, associated with social medicine in the inter-war years (Lewis, 1986), from concerns directed towards the social environment to concerns associated with individual behaviour (Armstrong, 1993). Utilitarian objectives directed towards improving health status for all, were carried out through measurement, the establishment of order and the containment of disease in populations (Lupton, 1995).

Nevertheless, as scholarship in this area has demonstrated (for instance, Lewis, 1986; Wear, 1992; Fee and Porter, 1992), the development of, and responses to public health, contain a number of tensions. First, in the late nineteenth century, public health was seen by some liberals as authoritarian and hence perceived as infringing upon individual rights. Those who identified with an anti-state intervention position advocated, alternatively, a more *laissez-faire* approach to public health which placed emphasis on individual responsibility. In contrast, those who, later in the twentieth century, criticised public health's authoritarian and interventionist position from a radical perspective, drew attention to both the tendency towards 'victim-blaming' (Crawford, 1979) and the failure of intervention to address structural problems in relation to health and illness. Political economists such as McKinlay (1984) for instance, advocated a stronger role for state intervention in order to address structural factors which underpinned poor health.

However, as Lupton (1995) argues, whilst we can identify traditional oppositions between the state and civil society, between gestures of

coercion and consent in the relationship between the two, the state, through public health, should not necessarily be understood as an instrument of oppression or disempowerment, from either the right or the left. This view presupposes power as hierarchical and sovereign, and reduces the relation of state and civil society to one of opposition. In contrast, Foucauldian frameworks have been arguing for a more productive model of power which allows us to examine the social sites in which practices and knowledges both constitute and regulate phenomena, such as prevention.

Whilst prevention policy largely developed in the 1960s, which I will discuss in more depth in Chapter Four, it was preceded by and premised upon diagnostic testing, carried out both in Local Authority clinics and in acute specialisms such as obstetrics and gynaecology. Preventive impulses drew on practices and values which were themselves premised on nineteenth century models of public health. The bacteriological revolution of Pasteur in the 1880s, which enshrined the principle of specificity (Fee and Porter, 1992), the growth of hospitals and the relative integration of pathology, physiology and chemistry, shored up the identification of disease in particular, specified populations (Wear, 1992). Mass screening stems from the importance to public health of early diagnosis in the early years of the twentieth century and the perceived threat of cancer in Western Europe and North America. Similarly, mass radiography for tuberculosis in the 1930s and mass serology for venereal disease in the 1950s can be viewed as precedents for the systematic screening which prevention has largely entailed.

Cancer detection emerged as a key target in the early part of the twentieth century, identified as the 'dread disease' (Patterson, 1987), riven with metaphor (Sontag, 1978) and the focus of extensive campaigns (Pinell, 1992). The publication of the *Dawson Report* (1920), for instance, enshrined the principle of diagnostic testing and disease detection in community populations (Armstrong, 1983). *The Cancer Act* (1929) advocated health centres for the detection of disease under the auspices of independent general practitioners and was geared towards the pro-active identification of cancer for the purpose of treatment and cure. The idea of diagnostic testing supported clinical observation and the principle of the

examination through a variety of procedures, such as the vaginal smear. Indeed, the female body was most often the body under scrutiny within this principal. Cancer in general was a significant preoccupation of the interwar period but cancer of the uterus and cervix became a particular preoccupation for gynaecologists, pathologists and general practitioners from the 1930s. For instance, cancer of the uterus was a specified target for intervention within the *Cancer Act* and by the late 1930s the cervix was targetted for systematic examination as a means of supporting the early diagnosis of disease.¹ Hence whilst the story told of diagnostic testing is in many respects familiar, it is important to note that it is a gendered story, since many of the tests developed in the interwar period were those made possible through physical and social accessibility to the female body.

The Female Body and Specialist Scrutiny of the Cervix

Much of the literature on the social organisation of medicine in the twentieth century implies a gender neutral body on which observations were made and tests developed. However, the female body in particular, as Chapter Two suggests, has historically been made accessible for medical scrutiny, for instance, both through Local Authority clinics and acute specialisms such as obstetrics and gynaecology. The establishment of women's hospitals in the nineteenth century supported physical access to the female body in general and to the cervix in particular, from at least the 1850s. The development of instruments such as the speculum in the mid-nineteenth century (Moscucci, 1990) enabled the direct observation of the cervix and surgical interventions were largely practiced on women in poorhouses, charity hospitals (Corea, 1985) and in psychiatric hospitals. Indeed by the end of the nineteenth century, the identification and removal of reproductive organs, defined as diseased, was discussed in medical journals as though it were entrenched practice within obstetrics and gynaecology. For instance, leucorrhoea, vaginal bleeding and general discomfort were all perceived within gynaecology as correctable pathologies,² and the removal of reproductive organs was practised on an

¹ R. Paterson wrote a 'special article' in 1942 drawing attention to the way in which the *Cancer Act* had emphasised the clinical observation of the cervix as a case for special consideration. *Lancet* 12 September, 1942:319

² A reading of *Lancet* from the nineteenth century provides discussion of surgical techniques such as cervical amputation and the removal of

experimental basis as an aspect of gynaecology's bid for specialist status (Moscucci, 1990).

By the end of the nineteenth century, gynaecologists had begun to clinically observe the cervix and by 1884, it was technically possible to examine the cervix microscopically.³ In the 1880s, the British Medical Association acknowledged the importance of microscopy in the observation and diagnosis of disease, and its potential for cancer detection, in order to provide treatment, was endorsed by the Medical Society of London, an organisation which also lent its support to the specialisation of both pathology and gynaecology. These two specialisms were already linked in particular places, such as Birmingham, London, Manchester and Edinburgh, through professional networks organised around Local Authority and University laboratories.⁴ The Edinburgh Obstetrical Society, in 1905, further highlighted the value of early diagnosis of cervical malignancy through curettage and microscopy.⁵ By the end of the nineteenth century the 'frequency' of cervical disease was of particular concern for gynaecologists,⁶ and by the 1920s, the microscope was increasingly favoured in gynaecological practice for observation of the cervix and case-finding. In contrast, during this period in North America, gynaecologists were explicitly urged to develop knowledge about the cervix and to develop a *preventive* agenda. A paper in the *American Journal of Obstetrics and Gynaecology*, suggested:

'We have entered the stage of prevention and it marks a new era in the progress of scientific medicine...[it is] important for every practitioner to acquaint himself with what a normal cervix is, so that he may appreciate the deviations from the normal and cure the cancer before it starts.'⁷

'diseased' reproductive organs (see for instance, *Lancet* 18 August 1826, 12(207):609)

³ Reported in *Lancet* 31 March, 1928:652

⁴ Tait (1974) draws attention to the relationship between Municipal Hospitals in Scotland and Local Authority laboratories. Close professional networks also allowed collaboration between gynaecologists and pathologists in parts of England.

⁵ Reported in *Lancet* 27 May, 1905:1427

⁶ This was noted by Professor Redfern in his address to the *British Medical Association* in 1884 and reported in *Lancet* 2 August, 1884: 201.

⁷ Huggins, R. R. 1922 'Precancerous conditions of the cervix uteri' *American Journal of Obstetrics and Gynaecology* (4):552

Treatment for cervical disease, was however, limited. The *Lancet* reported on surgical practice in relation to cancer of the cervix and illustrates the range of surgical techniques employed to combat cervical disease from at least the 1860s. These included vaginal hysterectomy;⁸ hysterectomy followed by the injection of 'anti-cancerous serum',⁹ and radium treatment from around 1910. An early procedure introduced in Vienna, in the 1860s, and discussed by London gynaecologists was also described in *Lancet* as an operation for detaching the cervix from the uterus using a 'galvano-caustic' wire.¹⁰ This procedure involved 'seizing the cervix' and pulling it with 'forceps and a sharp hook'. Thus in a number of ways, by the 1920s, the removal of the cervix on the basis of microscopically observed changes, was a standard surgical procedure in women's hospitals for the treatment of cervical disease. The self-retaining speculum, introduced in 1935,¹¹ made the cervix more accessible to gynaecologists. This accessibility was important for two main reasons. First, cancer was a focus for general professional discussion and cancer of the cervix was a particular focus for gynaecology. Second, in the 1930s, a number of texts and research publications suggested that cancer could be identified not only through clinical observation or histology, which examines a wedge of tissue, but also through the cytological examination of cells. These two concerns set the context for professional debate in gynaecology and pathology, around the nature of knowledge and the organisation of medical practice.

Cancer and Cytology

A key debate within gynaecology in the early years of the twentieth century was in relation to the natural history of cancer. It was recognised that early identification of cancerous tissue was important for effective treatment, which invariably involved surgical intervention and radium

⁸ A version of hysterectomy was commonly performed by the 1880s and was institutionalised in 1905 in the Wertheims's procedure by Victor Bonney. He was a prominent figure in the Royal College of Obstetricians and Gynaecologists, was appointed to the Chelsea Hospital for Women in the late 1890s (Moscucci, 1990). He collaborated with Commyns Berkely over the development of Wertheims specifically for the treatment of cervical cancer.

⁹ This technique was reported as 'Doyen's Anti-Cancerous Serum for Cervical Cancer' *Lancet* 25 March, 1905: 798

¹⁰ *Lancet* 2 August, 1884:201

¹¹ Reported in *Lancet* 24 June, 1937:226

treatment. Radium treatment, introduced around 1906, was controversial in the early years of the twentieth century, therefore those who advocated its place in the treatment of gynaecological cancer were keen to demonstrate its efficacy. However, in relation to cancer of the cervix, there was considerable diversity of professional opinion around the basis on which any classification of cancer could be made. Correspondence in *Lancet* in the early 1930s reveals the potential for confusion amongst practitioners in the variety of terms used to identify cervical cancer. These included *squamous celled carcinoma*, *basal cell carcinoma*, *squamous epithelioma*, *metaplasia*¹² The identification of cancer was a focus of attention because of the implications for treatment and the influence over results which the stage of intervention could produce. Of critical and lasting significance for participants of this debate was the way in which the rules for staging cancer could be interpreted differently by different observers.¹³ Therefore professional discussion in the 1930s and 1940s focussed on the rules for staging cancer and initially attended to the perceived distinction between *pre malignancy* and *malignancy*, cell typology and the causes and cures of cancer.¹⁴

¹² Correspondents included T. Stevens and A. Krompecher in *Lancet* 14 November, 1931: 965; 1104.

¹³ A 'special article' in *Lancet* draws attention to this problem in a report from the 1929 *Radiological Sub-Commission of the Cancer Commission of the League of Nations* which proposed revised rules for the allocation to clinical stages of cancer of the cervix. *Lancet* 1 October, 1938: 793

¹⁴ Of particular note is the division in this debate between those who advocated the dissemination of information to the public about cancer and those who did not. In 1937 the *International Congress of Medical Women* met in Edinburgh to discuss 'Cancer in Women' and identified the origins of cancer in trauma; hormones; marriage; children and inheritance. Dr. Elizabeth Hurdon of the Marie Curie Hospital in London co-ordinated the discussion which highlighted the way in which knowledge about cancer should be seen as incomplete. European medical women were seen to be partly in favour of 'anti-cancer propaganda' and in parts of Europe, there was support for highlighting the 'curability of cancer' on the understanding the such action would encourage people to present themselves earlier for treatment (Health Organisation of the League of Nations, 1939, *A Report on the Publications of Health and Medical Subjects*, London:1931 No. 66/1939 No. 89). In contrast, British medical women at this meeting were unanimous in their thinking that only doctors and nurses should hold information about cancer. It was believed by this group that information about cancer should not be incorporated into hygiene classes for young women nor should social workers be informed about cancer. In particular, regular gynaecological examinations were seen as undesirable because of their financial cost, the perceived dubiety of results and the false sense of security which such examinations were

The distinction between *pre malignancy* and *malignancy* became a focus for discussion in the late 1930s because of the growth of cytology, as a sub-specialism within pathology. In contrast to histology, cytology had the potential to examine many kinds of cells *in themselves*, such as liver and lung cells, and provided a means of observing changes in the shape, contour and movement of cells. In particular, cytology provided a means of observing *cervical* cells and was introduced into gynaecological and pathological practice through the work of Georges Papanicolaou. Papanicolaou's research, involving a series of studies in the 1920s, in the United States, focused on the oestral cycle of guinea pigs, as a means of gathering data regarding human reproduction. He developed a technique for gathering vaginal secretions with a curved tube and glass bulb, which he then examined for cellular changes related to ovulation, oestrin levels and the onset of menopause.¹⁵ The technique he developed to fix and stain the vaginal and cervical cells became known as the *Pap smear*.

In North America, gynaecologists primarily foresaw the eugenic implications of this work. In his inaugural address to the *American Gynaecological Society* in 1920, for instance, the president suggested that smear-taking would provide their specialty with the means with which to predict women *suitable* for childbearing and childrearing (my italics).¹⁶ There is less evidence of eugenic concern and fertility prediction as the key aspect of vaginal smear applicability in British medical debate. The emphasis here was more clearly linked to the potential for disease classification and drew directly on Papanicolaou's work on menopause.¹⁷

seen to provide. This latter issue was significant for doctors because of the way in which the provision of information could delay patients' advice seeking. It is worth noting that this has been a recurrent issue in professional discussion of cervical screening. I will return to this issue later in Chapter Three and again in Chapter Four.

¹⁵ Stockard, C. R. and Papanicolaou, G. N. 1917 'Dioestrons cycle in the Guinea Pig' *American Journal of Anatomy* 22:225. It is worth noting that Papanicolaou and his colleagues created their own human guinea pigs by conducting research on healthy hospital personnel (Papanicolaou, G. N. 1933 'The Sexual Cycle in the Human Female as Revealed by Vaginal Smears' *American Journal of Anatomy* 52: 519) and as Clarke and Caspar (1991a) note, even Papanicolaou's own wife provided vaginal smears on a number of occasions.

¹⁶ Dickinson, R. L. 1920 'A Program for American Gynaecology' Presidential Address read at the 45th Annual Meeting to the American Gynaecological Society, on 24-26 May, Chicago

¹⁷ Papanicolaou, G. N. and Shorr, E. 1936 'The Action of Ovarian Follicular

Collecting vaginal smears allowed him to draw up a table of classificatory changes in cervical cells which others used in their work on cervical disease. Papanicolaou made two points about his work which became key features of debate in British gynaecology and pathology. First, he asked the women in his study to take their own smears daily and observed that the vaginal smear was a simple procedure without 'inconvenience' or 'trauma' to the patient. Whilst this notion of simplicity has become an orthodoxy in professional and lay discussion of cervical screening, it is worth noting that women are not encouraged to take their own smears. Second, Papanicolaou and Shorr noted that whilst there was considerable potential for observer variability in smear interpretation, this could be mitigated by training. They said:

'..considerable experience is necessary to evaluate the morphologic changes in the vaginal secretion, which occur in the normal menstrual cycle and in menstrual disturbances, the alterations which we have described in this study are uniform and should be easily recognised by those trained in microscopic work.'¹⁸

Other researchers in the 1930s described how they collected vaginal smears to study the 'impenetrability of cervical mucosa' and its applications for sterility and artificial insemination,¹⁹ or for 'recognition of the oestrin reponse in women',²⁰ but the most significant application of vaginal smears and Papanicolaou's method of fixing and staining lay in the cytological examination of cervical cells for the detection of cancer. This method began to be used to identify cancerous cells and create a means of creating cell typologies and staging cancer.²¹ For instance, *Lancet* reported in 1941 on the different kinds of cells which could be found in

Hormone in the Menopause, as Indicated by Vaginal Smears' *American Journal of Obstetrics and Gynaecology* 31: 806

¹⁸ Papanicolaou and Shorr, 1936, *ibid.*, p822

¹⁹ Lamar, J. K., Skettles, L. B. and Delfs, E. 1940 *American Journal of Physiology* 129: 234

²⁰ Ucko, H. 1938 'Staining of Vaginal Smears' *Clinical and Laboratory Notes in Lancet* 17 December, 1938: 1413

²¹ Recruits for these studies were invariably women attending ante and post-natal clinics, gynaecological clinics, state psychiatric hospitals in North America and women who were inpatients for a variety of reproductive and gynaecological disorders. These early studies were non-randomised and subject to a great deal of criticism within British gynaecology because of the perceived difficulties of interpreting the results of cytology.

the cervix and vagina and drew attention to the ways in which cells could migrate from one part of the cervix to another.²² The significance attributed to the observation of cell migration was the way in which this process could simulate localised cancer. This was interpreted by some as evidence that *pre malignancy* or *precancer* did not exist, but that the discovery of cells from one part of the cervix in another could be identified as *localised metaplasia*. The introduction and expansion of cytology therefore sharpened debate in relation to cancer staging by dividing opinion between those who argued for a relative distinction between a *precancer complex* and *carinoma-in-situ*, in recognition of what was increasingly understood as a disease process, and those who argued for an absolute classification system which would acknowledge the distinction between localised disease and more widespread cancer. The key distinction here was between a disease in place, as localised malignant growth, or cells in transition across both space and time, which alluded to a disease process.

A second major and recurring concern within both pathology and gynaecology was around the reliability of cervical specimens. As early as 1925, one pathologist warned his colleagues in the *Lancet* of the potential for misinterpretation. He said:

'At the same time, it is well to bear in mind that this resemblance to...carcinoma of tissue cultures...is merely morphological and may be no more than the manifestation of growth under abnormal conditions. It may, in fact, bear the same relation to cancer as the noise and clatter of a passing train has to the electricity that moves it.' ²³

Later commentators, in the 1940s, who took vaginal smears and used them to identify cancer cells, noted that differences of opinion about the identification and staging of disease might reflect differences in the skills of observers. For instance, an anonymous author in *Lancet* observed that:

²² Reported as an 'Annotation' in *Lancet* on 'The Significance of Cervical Metaplasia' 12 April, 1941: 486

²³ Dr. R.J. Ludford described nuclear changes in the fibroblasts of rats which may be associated with abnormal conditions of growth and nutrition, such as cancer. *Lancet*, 24 October, 1925:876.

'vaginal smear studies are in vogue but are extremely difficult to interpret; even the few experts with adequate experience admit a comparatively high percentage of errors in diagnosis.'²⁴

These two issues were highlighted in 1941 with the publication of Papanicolaou and Traut's classic text on vaginal smears in uterine cancer.²⁵ First, the authors highlighted the vaginal smear, which denoted both the technique of collecting secretions and cells and the method of fixing and staining the specimen, as a simple method of diagnosing malignancy before lesions became detectable by biopsy (that is, cervical cancer as process). The crucial distinction made by the authors here was that the *Pap smear* allowed clinicians to identify cancer at the level of the cell rather than at the level of tissue examination through histology. Second, Papanicolaou and Traut acknowledged the potential for interpretive discrepancies, but argued that a high degree of microscopic skill would reduce this, thus ensuring a specialist function for cytologists. Finally, they further drew attention to the role of error, particularly that of 'false' negatives, by pointing out that one negative smear should never be taken as a definitive indication of the absence of malignancy, thus reinforcing the potential for flexible disease classification.

Similarly, Gates and Warren (1948) pointed out in their *Handbook for the Diagnosis of Cancer of the Uterus by use of Vaginal Smears*, that:

'good, bad and indifferent results may be obtained by different people following the same directions: each worker must set up his own criteria.'²⁶

These authors noted first that subjective knowledge played its part in the the identification of malignant cells. Second, they noted that malignant cells could more easily be identified in cervical cells than in histology, but

²⁴ 'Annotations' in *Lancet* 13 November, 1948:486

²⁵ Papanicolaou, G. N. and Traut, H. F. 1941 'The Diagnostic Value of Vaginal Smears in Carcinoma of the Uterus' *American Journal of Obstetrics and Gynaecology* 42(2):193

²⁶ The Gates and Warren text reproduced here is cited by Kraushaar, O. F., Bradbury, J. T. and Brown, W. E. 1949 'The Vaginal Smear in Population Screening for Uterine Cancer' *American Journal of Obstetrics and Gynaecology* 1949 (58):519

that 'misleading' smears could be repeated, hence incorporating an implied culture of surveillance, albeit in relation to hospital populations. They argued that the malignancy potential of cells could be identified by 'relative rather than absolute changes in structure', therefore establishing a more flexible notion of disease classification which acknowledged intersubjective variability *and* uncertainty in cancer cell identification.

Scholars have described elsewhere (Davidson, 1993), how the professional expansion of medicine in the interwar period, through specialisation, became the means through which resources could be claimed, boundaries established, and new methods of practice consolidated (Freidson, 1970). Classificatory systems were an integral aspect of professional criteria as a basis for medical practice and diagnosis (Armstrong, 1983) and expressed distinctions between clinical and laboratory medicine. Therefore concerns about smear reliability and validity expressed conflict between pathology and gynaecology around divisions of labour in the collection and interpretation of cervical cells and judgement about therapy. Who was best placed to collect and interpret cells, and ultimately act on the information they provided? Furthermore, such debates reflected more general concerns about the validity of medical knowledge and the relationship between bedside medicine and laboratory science (Sturdy, 1992). Gynaecologists and pathologists perceived gaps in what their techniques could provide, and focused largely on identifying typologies of cells which formed the most common types of cancer, mostly using the Papanicolaou classification. However, there was no consensual classificatory system to establish clear boundaries between non-malignant and malignant cells, therefore knowledge about cell typology was, presumably, embodied in particular persons in local laboratories.²⁷

On the one hand, there were those in gynaecology who emphasised the importance of clinical observation and who therefore perceived collaboration between gynaecology and pathology, or the scientific

²⁷ MacKenzie and Spinardi (1995) describe a general process of knowledge embodied in local persons in relation to the nuclear weapons industry. More significantly, Shapin (1994) outlines the embodiment of knowledge in particular persons in the context of science-making in laboratory contexts.

validation of clinical observation, as a threat to their clinical autonomy. As Sturdy (1992) notes, many clinicians were sceptical of laboratory science in general because of the perception that laboratory medicine would undermine or be prejudicial to 'good', or bedside, practice. On the other hand, there were gynaecologists who perceived that specialist status, distinct from obstetrics, could be supported by exploiting the institutional links and personal networks between gynaecologists and pathologists which smear-taking could provide. In common with the evolution of other medical specialisms, those who took the latter view saw the laboratory as a resource for investment and the production of knowledge (Sturdy, 1992) and furthermore, saw gynaecology as a surgical field based on a scientific approach to the body. For instance, the second edition of *Diseases of Women* in 1931,²⁸ made clear that 'clinical knowledge' could only develop on the basis of interaction between clinical and interpretive observations, hence between hospital and laboratory medicine.

Those who took the latter view, in hospitals such as the *Chelsea Hospital for Women* or the *Royal Cancer Hospital*, enshrined smear taking as part of their routine gynaecological practice. This was largely linked to the way in which cervical cytology was used to evaluate surgical intervention and radium treatment for gynaecological cancers. By the 1940s Wertheim's hysterectomy and radiotherapy were the standard forms of treatment for cervical and other forms of gynaecological disease, and vaginal smear-taking provided a means of both case-finding and treatment evaluation. Indeed, smear-taking and cervical cytology were central to debates between the relative value of Wertheim's hysterectomy and radiotherapy in the treatment of cervical cancer,²⁹ and were employed to confirm the success of these techniques.

However, key figures in the debate between surgery and radiotherapy, who relied on smear-taking as a way of demonstrating success, also voiced

²⁸ The first edition of *Diseases of Women* was published in 1902 and linked gynaecology to pathology and therefore to scientific medicine.

²⁹ The *Conference on Gynaecological Cancer* at the Royal Victoria Infirmary in Newcastle, drew attention to a particular discussion of the relative merits of surgery and radiotherapy. Reported in *Lancet* 16 April, 1949: 665.

criticisms about the accuracy of disease staging afforded through cytology, and the lack of consensus between clinicians around disease classifications, on the grounds that this confused the issue of whether or not surgery was required, and when. Hence, whilst smear-taking entered routine gynaecological practice in centres which sought to establish the relative merits of surgery and radiotherapy in the treatment of cervical and uterine disease, and where cytology was possible because of established links between gynaecology and pathology, there continued to be considerable debate around both staging and interpretation in the 1940s and indeed the 1950s. Furthermore, cytology was rarely employed as a sole means of disease identification and histology continued to play an important role, through the biopsy. Consequently, the 'pathological gaze' was given a means to develop, through the expansion of cytology, but clinical judgement in gynaecology was also retained (Clarke and Caspar, 1991a), since cytological results could never be taken as definitive, and therefore expressed areas of contested knowledge.

Knowledge, Interpretation and the Genesis of Screening

With the publication of work on 'The diagnostic value of vaginal smears in carcinoma of the uterus' in 1941,³⁰ Papanicolaou and Traut pushed forward debate around cancer detection and smear-taking. The authors highlighted the perception of high rates of mortality from uterine cancer since the 1920s and noted the arguments for early diagnosis, in order to enhance treatment, which gynaecologists had articulated during this period. The paper graphically presented the characteristics of cancerous cervical cells and Papanicolaou and Traut identified the mass applicability of vaginal smears for cancer diagnosis. They certainly foresaw the elimination of more traumatic diagnostic methods, such as tissue biopsy. However, at this point in time, they also drew attention to the limits of vaginal smears, both in relation to the difficulties of interpreting cancerous cells 'out of context' and by recommending vaginal smears as a preliminary sorting procedure, rather than as a means of ultimate diagnosis.

Other studies of the applicability of vaginal smear taking followed, drawing sample populations from University hospital inpatients, women

³⁰ Papanicolaou and Traut, 1941 op. cit., p193

inmates of psychiatric institutions and occasionally, 'volunteers'. These studies intensified controversy over whether this technique was more valuable as a screening or sorting procedure or as a diagnostic tool. The key issue here lay in the status of tissue biopsy and the extent to which vaginal smears would replace the biopsy as a diagnostic tool. This issue again reflected concerns about the validity of smears and those more equivocal about its value as a diagnostic technique highlighted their unreliability, pointing to the high rates of 'false' positives and negatives produced in published studies.³¹ However, those who supported the value of smear-taking tended to highlight its value as a preliminary sorting procedure which was not oriented towards diagnosis, but rather screening. For instance, Gates and Warren, again, in support of the position of Papanicolaou and Traut, argued:

'Overemphasis on the statistical accuracy seems to put the stress in the wrong place. If the method is to be used as a preliminary or sorting procedure, the degree of accuracy is unimportant within reasonable limits. The thing that matters is whether the method will discover cancer and initiate treatment earlier than would otherwise be done.'³²

Hence the work of Papanicolaou and Traut established the principle of smear-taking as a screening procedure which could operate in tandem with other methods of cancer diagnosis. Smear-taking at this point was not intended as a replacement for biopsy or clinical observation but promoted on the assumption that its use in any context would require other examinations and investigations. Furthermore, such a position reinforced controversy over the processes and organisation of interpretation. A potential solution to the difficulty of interpretation was the:

'...intimate and critical knowledge of cytology required for a correct interpretation.'³³

³¹ Kraushaar, O. F., Bradbury, J. T. and Brown, W. E. 1949 highlight this controversy in their paper 'The Vaginal Smear in Population Screening for Uterine Cancer' *American Journal of Obstetrics and Gynaecology* (58):519

³² Quoted from Gates and Warren, 1948, cited by Kraushaar, O. F., Bradbury, J. T. and Brown, W. E. 1949, *ibid.*, p519

³³ Papanicolaou, G. 1945 'A general survey of the vaginal smear and its use in research and diagnosis' *American Journal of Obstetrics and Gynaecology* 51: 315

In other words, interpretation would cease to be a problem if cytology was enabled to develop professional and disciplinary expertise. Therefore, throughout the 1950s, in both North America and Britain, debate on the gynaecological application of vaginal smear-taking focused on establishing the reliability and validity of smear-taking, not as a diagnostic tool, but rather towards establishing its value as a screening procedure. This centred on both the interpretation of cervical and vaginal smears as well as the technique of smear-taking itself. For instance, research in North America compared different methods of smear-taking,³⁴ and the work of J. Ernest Ayre, to a great extent resolved differences of opinion around the technique of smear-taking and illustrated the extent to which cytology itself had grown as a specialty during the 1940s.³⁵ However, in a review of Ayre's book, an anonymous author in *Lancet* highlighted the sustained contention embedded within the discussion and practice of smear-taking. In particular, the author drew attention to the persistently debated distinction between a *precancer complex* and other definitions of cancer, and the inability of cytology to make this distinction. Nevertheless, Ayre's method of smear-taking became a more acceptable procedure to many gynaecologists but remained controversial to those outside the enclave engaged in routine smear-taking.

The opposition of laboratory knowledge to clinical practice, and the issue of how adequacy in smear interpretation was constituted, continued to characterise debate in the 1950s. Gynaecological research in Britain continued to focus on the classification and staging of cervical disease, but increasingly in the 1950s, on the reliability of the cervical smear as a diagnostic technique. Whilst debate in North America crystallised around the applicability of smear-taking as a screening procedure, in Britain, concern in the early 1950s tended to centre on issues of interpretation in relation to diagnosis. In Britain, gynaecologists remained the main users of smear-taking as a means of case-finding. Smear-taking was perceived as a critical means through which women with cervical disease could be

³⁴Hyams, M. N., Hyams, R. G. and Wainess, E. 1950 'Direct Contact Vaginal Cytology Smear Technique' *American Journal of Obstetrics and Gynaecology* (59): 445

³⁵ Ayre, J. 1953 *Cancer Cytology of the Uterus* reviewed in *Lancet* 31 January, p225

identified for surgery, although there continued to be considerable debate around what constituted 'successful' surgery, prompting the *Royal College of Obstetricians and Gynaecologists* to set up a clinical cancer research committee, which in part, entailed scrutiny of smear-taking.³⁶ Consequently, studies carried out in gynaecology centres, for instance in Birmingham and Manchester, continued to triangulate the use of vaginal and cervical smears with biopsies for the histological examination of cervical tissue.

During the 1950s British gynaecological debate continued to focus on issues of interpretation, acknowledging the problem of subjectivity and the problem of relative as opposed to absolute cells changes. In addition, debate focussed on disease staging and classification; on whether *precancerous cells* or *carcinoma-in-situ* existed at all and whether this could be identified through cytological examination. A number of studies were carried out in hospitals in England with the purpose of clarifying this distinction.³⁷ Much of this work was equivocal, despite extensive applicability of smear-taking during the course of related research. Results from this corpus of research was therefore subject to sustained debate. Some advocated a cautious approach to the value of cytology for either diagnosis or screening. *Lancet* took the view, early in 1960, that cytology could reveal some cervical cancer but would also miss cases, suggest its presence when it did not exist and therefore should not be used as a routine screening procedure.³⁸ This view was underpinned by the publication of a case study,³⁹ which recounted the story of three sisters

³⁶ 12th British Congress of Obstetrics and Gynaecology reported in *Lancet* 23 June, 1949: 166

³⁷ Papers published in *Lancet* provide evidence of these studies. Blaikley, J. B., Lederman, M. and Lewis, T.L.T. 1952 'Results of Treatment of Cancer of the Cervix' *Lancet* 15 November p950; *British Journal of Cancer* 'Annotation' 1949 (3):433; Heyman, J. (ed) 1949 V Volume of *Annual Reports on Results of Radiotherapy in Cancer of the Uterine Cervix*; Blaikley, J. B., Lederman, M., Simmons, C.A. 1957 'Carcinoma of the Cervix and the Chelsea Hospital for Women 1933-56' *Lancet* 28 December, p1329

³⁸ 'Setting a Whale to Catch a Sprat' *Lancet* 3 December, 1960: 1239 presented an assessment of published research which compared clinical findings in 8522 gynaecological cases with microscopic examination of 10,000 smears and biopsies (cited from Boddington, M. 1960 in *British Journal of Cancer* (14): 151)

³⁹ Way, S., Hetherington J., M Galloway, D.C. 'Simultaneous Cytological Diagnosis of Cervical Cancer in Three Sisters' *Lancet* 21 November, 1959: 890

who were all found to have cervical cancer. The first sister presented with backache, had a positive (or abnormal) smear and subsequently had a radical hysterectomy (which involved the removal of her uterus, ovaries, upper third of her vagina and inner half of parametrium). Simultaneously, a second sister presented with persistent bleeding, had an abnormal smear and subsequently a vaginal hysterectomy. The third sister, solicited by the consultant reporting the case, had no symptoms, but had a positive smear and a hysterectomy was duly performed. In all three cases, invasive cancer was not confirmed, therefore highlighting the interpretive difficulties involved for a general medical audience, and highlighting clearly, an emerging ethical issue around surgical intervention in the case of young women with suspected cervical disease.

However, other published research was unequivocal about the value of screening despite less than certain results. For instance, a report from a team at the Birmingham and Midland Hospital for Women discussed how smear-taking had been part of routine gynaecological practice of outpatients. Cytological reports were triangulated with histology,⁴⁰ and clinical examination to investigate the accuracy of cytology. The authors argued that cytology failed to pick up all *carcinoma-in-situ* identified in the study. Nevertheless, they suggested that while :

'cytology may be of value to the clinician in the diagnosis of invasive cancer of the uterus, our experience suggests that only rarely will the technique discover an unsuspected lesion. The most important use of cytology lies in its ability to lead the clinician to a diagnosis of *carcinoma-in-situ* in the clinically normal cervix.'⁴¹

Therefore the results of this study further supported the use of cytology as a *screening* or *sorting* procedure, rather than as a diagnostic tool, a view which was increasingly endorsed by other experts with an interest in cancer detection.⁴² This reflected the extent to which distinctions

⁴⁰ McLaren, H.C., Taylor, C.W., Attwood, M.H. 1958 'Cytological Diagnosis in Gynaecological Practice' *Lancet* 22 February, p398 Histological triangulation meant that all 4250 women in the study were subjected to ring biopsies. The authors also report that these women also had dilatation and curettage.

⁴¹ McLaren et al 1958 *ibid.*, p398

⁴² For instance, the VII International Cancer Congress met in London and

between *carcinoma-in-situ* as disease in place and cells in transition were unresolved, yet paradoxically, provided a means of resolving debate. By designating cytology as a screening procedure, cervical disease was effectively designated a trajectory, or a continuous disease process, along which intervention could potentially occur at a number of points (Clarke and Caspar, 1991b).

The impossibilities of diagnostic certainty shifted debates in the use of cytology towards a more explicit focus on screening non-clinic populations. Screening within gynaecology was increasingly seen as a feasible sorting procedure within clinic populations and in some centres had become routine as a means of surgical case-finding. In 1962, gynaecologists, pathologists and cytologists formed the *British Society for Cervical Cytology* to increase the visibility of cytology and advocate, controversially, screening of all healthy women. The *First International Congress of Exfoliative Cytology* which took place in Vienna, sponsored by the *International Academy of Gynaecological Cytology*, argued that:

'...carcinoma of the cervix must now be accepted as a preventable disease, at least in women *who are willing to submit regularly to cytological tests*' [my emphasis].⁴³

Further, the *British Society of Cytologists*, argued that:

'...the value of exfoliative cytology in detecting accessible cancers, especially in the cervix uteri, has been demonstrated beyond cavil.'⁴⁴

Nevertheless, debate persisted on interpretive issues, as before, but also, increasingly, turned to issues of cost and organisation. The *BSCC* in particular were keen to demonstrate that scepticism around screening was much more the consequence of inadequate investment and funding than about the knowledge base of pathology and cytology. This new turn signalled the entry of general practice into debates around cytology, through the notion of prevention.

discussed the value of cervical cytology as a screening method to find cancer cases, reported in *Lancet* 19 July, 1958: 139

⁴³ Reported in *British Medical Journal* 7 October, 1961: 453

⁴⁴ Wilson, J.M.G. and Cantab, M.B. 1963 'Multiple Screening' *Lancet*, 13 July, p51-54

The Pap Smear Test: From Gynaecology to General Practice

In the 1940s and 1950s, smear-taking was confined to clinic and hospital populations. During this time in North America, smear-taking began to be seen, not as a sorting procedure for women with clinical signs of gynaecological disease, but rather, as a means of screening the general population for signs of pre-clinical disease. Whilst this new perception emerged within Public Health in North America, in Britain, it did so, though not without contest, within general practice. The growth of hospital facilities in the 1950s, such as diagnostic laboratories, presented opportunities for community physicians to liaise and communicate with the growing acute sector and also, crucially, link general practitioners to wider specialist networks. There were regional differences in these relationships. In North-East Scotland for instance, the Department of Obstetrics and Gynaecology, the Family Planning Clinic and general practice were well networked from around 1958 and had access to hospital pathology laboratories. This network was further strengthened because of the way in which the practice of testing for venereal disease in the interwar period ensured general practice access to diagnostic laboratories (Tait, 1974), in ways which also provided a structure through which to develop screening. Published work in 1963 'proved' the diagnostic value of cytology in the general population and advocated more extensive population coverage to detect pre-clinical signs of disease.⁴⁵ This view was upheld by the editorial of the *British Medical Journal* which drew attention to a pilot study funded by the *British Empire Cancer Campaign*. This supported the evaluation of screening as a method of detecting pre-clinical signs of cervical disease in Edinburgh, Aberdeen and Glasgow.⁴⁶

A cytological service was initiated in Edinburgh in 1949 and in Glasgow in 1955, linking hospital laboratories, with University and public health doctors.⁴⁷ Other regions, such as Manchester, utilised similar networks.⁴⁸

⁴⁵ MacGregor, J.E. and Baird, D. 1963 'Detection of Cervical Carcinoma in the General Population' *British Medical Journal* 22 June, 1963: 1631

⁴⁶ Leader 'Preventing Cancer of the Uterine Cervix' *British Medical Journal* 30 July, 1962: 1818

⁴⁷ Grant, M.P.S. 1961 'Cytology Prevention of Cancer of the Cervix' *British Medical Journal* 22 June: 1637

⁴⁸ 'Cytological Screening for Cancer of the Cervix' leader in *British Medical Journal* 22 June, 1963: 1625, reported on the relationship between Manchester Hospital Board and general practice in developing cervical

In the 1960s, the Scottish Health Department enlisted the cooperation of Local Authorities to expand this service, by providing clinical teams to carry out cervical screening of non-clinic populations. Hospitals were encouraged to provide the hospital facilities and required to process smears which were collected. This linkage of networks provided a means of analysing smears taken within the community, rather than within hospitals and established 'the cervix' as an entity to be scrutinised within a community setting. Furthermore, the introduction of screening produced an illusion of 'background prevalence' in the community which was never completely justified.⁴⁹ Nevertheless, it was assumed that levels of cervical disease in the community would match those of hospital populations, and indeed, the presumed detection of high background prevalence was central to the argument about the validity of the Pap smear test as an efficacious and valid screening tool. This perception fuelled a number of trials and studies, which, like other studies in relation to disease classification and cytology interpretation, were equivocal.

However, in Scotland, the publication of results from one particular survey within general practice set a precedent for the routinised screening of women in the community.⁵⁰ This research focussed on a sample of 1000 women who attended post-natal and family planning clinics, had menopausal symptoms and had any kind of pelvic examination. Of these 1000 women, fifteen women were found to have unsuspected cervical cancer in an otherwise clinically normal cervix. All of these women were then subjected to ring biopsy to confirm a diagnosis of cancer. Four women had cervical amputation and six had hysterectomy. Although high background prevalence was not identified in this study, the report highlighted the fact that the numbers of cancer detected were higher than in published reports of other studies on hospital populations. This point alone was used to argue that smear taking could and should become a routine feature within general practice.

However, the measurement of background prevalence was contentious

screening

⁴⁹ I draw this insight from Davidson (1993), who argues that the introduction of syphilis testing in the postwar period heightened awareness of the potential for disease.

⁵⁰ A report by the South-East Scotland Faculty of the College of General Practitioners 'Cytological Screening of 1000 Women for Cervical Cancer' *Lancet* 1958, ii: 895

within general practice because of the perceived unreliability and invalidity of the Pap smear, especially in terms of 'false' positives. This contention focused largely on the dangers of asking healthy women to submit to a test which could result in partial removal of the cervix or hysterectomy.⁵¹ Sceptics focused on the absence of clear treatment for *carcinoma-in-situ* and variations in treatment from clinic to clinic. Furthermore, criticism of the idea of more widespread screening focused on absence of clarity around the staging of disease, drawing attention to the enduring and unresolved distinction between abnormal cells as cells in transition, which could regress to normal and therefore never develop into cancer, or cells in a premalignant stage.

For those less supportive of routine screening, a significant factor was that some treatment would be unnecessary and therefore effectively sterilise young healthy women. Such criticism argued that research should focus instead on the stage at which treatment was necessary rather than the introduction of mass screening.⁵² Supporters, in contrast, argued that *carcinoma-in-situ* could be identified through routine screening and should be brought to the attention of gynaecologists for surgical removal.⁵³ This position effectively shored up the case-finding strategy adopted within gynaecology. Therefore debate was characterised by either conservatism or radical interventionism and turned increasingly in the 1960s to discussion of facility provision and organisation. It was not thought that the idea of screening should be abandoned altogether, but that screening ought to be better targetted in order to find as high a number of abnormal cases as possible.

As practitioners joined gynaecologists in smear-taking, pressure on laboratories began to rise and thus debates ensued in the medical press about the need to train and increase technicians to interpret and process cytology slides. The *British Society for Cervical Cytology* too, joined in more

⁵¹ Correspondence between Elliot, R.I.K and MacLaren, H. 1963 in the *British Medical Journal* illustrates the force of this contention 3 August, p318

⁵² A selection of criticisms was found in Howe, R.H. 1950 *Obstetrics and Gynaecology Survey* (5):621; Fennell, R.H., Castleman, B. 1955 *New England Journal of Medicine* (252): 985; Dilwarth, F.E., Maxwell, G.E. 1962 *AJOG* (84): 83.

⁵³ Boyes, D.A., Fidler, H.K., Lock, D.R. 1962 *British Medical Journal* (i): 203

general expression of these concerns. The absence of facilities for diagnostic cytology and the need for training surfaced as a key concern, in particular, whether cytology technicians should be 'all round' laboratory technicians or whether specialist training should be provided. These debates recognised the subjective nature of the work and stressed the importance of professional competence through examination and credentialism. Intraobserver variability emerged as a significant, unresolved, issue which reflected professional anxieties about the scientific nature of cytology and a perceived inability to reproduce interpretations across different laboratories and different groups of workers.⁵⁴ The unresolved nature of these anxieties, shored up the arguments of those who advocated routine screening as a basis for further investigation, as an entry into close and constant observation, or surveillance.⁵⁵

A means of managing professional anxieties about interpretive ambiguity, was selective screening, and in part, this also reflected uncertainties about general practice and its position within emergent National Health Service organisation. General practice was experiencing its own restructuring in the late 1950s and early 1960s, in response to perceived deskilling as a consequence of the entrenchment of the District General Hospital. General practice was seen, from within, as potentially losing skills, and screening was seen as an opportunity to expand practice and feed into specialisation. This was reflected in the discussion of prevention within general practice which specifically drew attention to the possibilities of being reorganised around cervical screening.⁵⁶ Some argued that the division of labour around screening could favour general practice as the principle smear-takers, but also general practice could re-establish technical expertise by having open access to hospital pathology laboratories.⁵⁷

⁵⁴Correspondence between Vickers, H.E.; Philips, F.R.; and Lederer, H. draws attention to these anxieties in *British Medical Journal* 22 September, 1962: 601-608

⁵⁵ Donaldson, M. writing in *British Medical Journal* 6 October, 1962: 723

⁵⁶ See *The General Practitioner and Preventive Medicine* 1966 Report of the Joint Meeting of the Royal Society of Health and the College of General Practitioners on the Role of the GP in Preventive Medicine

⁵⁷ Leading article 'Screening' *Lancet* November 9, 1963:987-988

The Royal College of General Practitioners expressed this potential in their 1966 report.

'Another important preventive field in which the GP and the hospital (and sometimes the Local Health Authority) will increasingly combine is that of presymptomatic diagnosis. Cytology to detect premalignant changes in the cervix, the early detection of anaemia, of phenylketonuria, of diabetes and of glaucoma all come more and more within the ambit of the GP backed by the appropriate hospital department.'⁵⁸

It was argued that prevention ought to be located within general practice as a means of sophisticated community surveillance, in which the general practitioner would play a pivotal leadership role. Professional anxieties over the future role of general practice, in the light of the development of social medicine, and the ambiguous role of public health, by mid-century, provided the context in which debates around screening were carried out (see Lewis, 1986; Webster, 1988 for elaboration of the changing role of general practice and the re-organisation of the health services). Concerns around the institutional location of patients certainly raised issues around the boundaries between wellness and disease, but these boundaries were further embedded within professional boundaries.

General practice saw prevention in general, and screening in particular, as a way of consolidating its position within the emergent organisation of health care. There were sceptics however, since some practitioners perceived smear testing as a way of decreasing their clinical autonomy,⁵⁹ by replacing clinical examination with screening tests which pathology would judge and gynaecology would treat. This view stressed the importance of retaining clinical decision-making for patients within general practice and not having to carry out treatment on the basis of other professional decisions. There are parallels here of course to earlier concerns within gynaecology and Freidson (1970) has documented how this position is more generally reflected in the development of medicine as a professional group. Other practitioners cautioned that idealism within general practice obscured the realities which routine screening

⁵⁸ RCGP, 1966, op.cit. p24

⁵⁹ *Lancet* 20 July, 1963; 'The Report of the 113th Session of the Edinburgh Obstetrical Society' also expressed this view in *Scottish Medical Journal* 1960 (5): 185

would entail.⁶⁰ Nevertheless, despite anxieties about professional boundaries, the *British Medical Association* tried to encourage general practitioners to see the professional payoff in adopting screening. A leading article in the *Lancet* further suggested that mass screening would link general practitioners more firmly to obstetrics and gynaecology.

Where the emphasis within gynaecology was placed on diagnosing cervical cancer with a view to treating the diagnosis surgically or by means of radiation, within general practice there emerged a view that the cervical smear test could be linked to the new, growing epidemiology and applied selectively to *targetted* groups of women. This emerging discourse within general practice was linked to social medicine and more concerned with defining specific populations than with case-finding, in part as a means of managing limited resources. The smear test, therefore, increasingly began to operate as a mechanism for linking general practice and gynaecology, and a mechanism through which referrals might be institutionalised.⁶¹

By the early 1960s smear-taking had become increasingly routine in both gynaecology and general practice. Furthermore, debates about cervical screening had shifted and were no longer only between pathologists and gynaecologists, but were also increasingly engaged in by those with an interest in public health, general practice and social medicine. This shift reflected the scientific acceptability of the Pap smear in North America where its screening potential had been widely accepted earlier. Population screening trials had been initiated by several public health departments on an experimental basis.⁶² Multiple screening, in particular, was seen as a solution to the chronic disease in ageing Western populations, such as diabetes, arteriosclerosis, glaucoma and 'accessible' cancers. This recognition further supported the development of cervical

⁶⁰ Allday, R.K. writing in *British Medical Journal* 20 July, 1963

⁶¹ Clarke and Caspar (1991b) argue that the Pap smear test should be seen as a boundary object because of the way in which it operates in different social worlds and networks. Whilst I am not using the term because of the significance it attaches to the object as technology, rather than the social context and relations in which the object is used (see Banta, 1983), it is nevertheless valuable as a way of observing how different social groups adopt the same technology in a variety of ways.

⁶² 'Cytology of the Cervix' leading article *Lancet* March 2, 1963

screening. Its focus however, was on women of childbearing age rather than on an ageing population.

Multiple screening, as a public health measure, was developed in the form of experimental schemes, with the financial support of the United States Public Health Service in the late 1940s. Screening was institutionally and conceptually located within public health departments and, in theory, oriented towards two key objectives. First, it was committed to the idea of detecting pre-symptomatic disease. Second, the economic incentives to do this were considered vast. Multiple screening was clearly perceived within public health as a cost reduction exercise and screening for signs of pre-clinical disease was seen as a way of reducing time invested in medical examinations, laboratory investigations and follow-up examinations. A third, implicit, objective, may have been, in the North American context, in relation to providing medical care for a 'medically underprivileged' community.⁶³

There are distinctions to be made between the development of screening in the USA and Britain, particularly with reference to the organisation of medical practice. By 1963, screening in the USA was already part of a wider public health apparatus, organised through public health departments as experimental programmes with financial support from sources such as the U.S. Public Health Service and Chronic Diseases Division of State Services. It is worth noting that mass screening in North America was also feasible because it addressed relatively accessible populations through public health departments which, by and large, dealt with populations characterised by poverty. Furthermore, cervical screening was not initiated as a discrete measure but was part of a wider exercise designed to screen for a number of maladies, in contrast to diagnostic testing in Britain which was concentrated upon cervical screening.

However, there were voices of opposition to mass screening in North America which were mirrored in Britain. Late in the 1950s, a growing voice of opposition to screening emerged within American medicine, articulating three key concerns. First, the need for an integrated

⁶³ Wilson, J.M.G. and Cantab, M.B. 1963 op. cit., p51-52

programme of diagnosis, follow-up and treatment was seen as paramount.⁶⁴ In Britain, in the mid 1960s, concerns centred on both the organisation of screening and the provision of diagnostic facilities. By 1964, setting the context in which the Platt Committee could identify screening as a way of incorporating prevention into general practice agenda, the *British Medical Association* was urging general practitioners to practice Pap smears.⁶⁵ Furthermore, the Ministry of Health issued a memorandum agreeing in principle that routine screening for cervical cancer ought to be available in general practice and subsequently set up five cytological training centres.⁶⁶

Second, there were recurring and persistent concerns over the validity of certain screening procedures. Third, significantly, others raised the issue of:

'the risk of regarding the population with negative screening tests as necessarily healthy, and not in need of medical care.'⁶⁷

Embedded within such statements, is a collapsing of boundaries between notions of the normal and the abnormal, substituting them with a continuum of abnormality along which individuals might require medical surveillance and intervention.

General Practice and Professional-Client Concerns

Medical debate in the late 1950s and early 1960s, on the issue of pre-symptomatic screening, was sharply aware of the potential for reshaping boundaries between health, illness and disease. During the early 1960s many debates around screening in general were crystallised in a way which opened up the possibilities for cervical screening in particular. One such concern emerged around the institutional location of patients. Both the Royal Society for Health and the Royal College of General Practitioners identified general practice as the logical co-ordinator of all

⁶⁴ Mountin, J.W. 1950 *Publ. Hlth. Rep.* 42:1359 cited in Wilson and Cantab *ibid.*, p52

⁶⁵ BMA Annual Meeting 'Medicine in the Sixties' reported in *British Medical Journal* 1 August, 1964: 302

⁶⁶ *British Medical Journal* 10 October, 1964: 956

⁶⁷ Smillie, 1952, cited in Wilson and Cantab, *op. cit.*, 1963 p52

local authority services. This was a view endorsed by the *Royal College of Obstetricians and Gynaecologists*, who argued that family practitioners should liaise between women, gynaecologists and pathologists.⁶⁸ In order to develop a central preventive role, general practice perceived that it would have to be able to make claims on other health services. The incorporation of hospital laboratories, in particular, were seen crucial to the development of screening and for the identification of specific and identifiable populations.

However, general practice also perceived potential problems of access to diagnostic laboratories and argued:

'The general practitioner must receive unrestricted help with diagnostic facilities in order to achieve success in this field.'⁶⁹

This was acknowledged by a *Lancet* editorial which highlighted the need for general practice to appropriate screening as one of its functions in collaboration with hospital laboratories and local health authorities.⁷⁰ In this way, screening as a case-finding exercise could be managed by health authorities and could serve as a feeder for specialists within hospitals. Importantly within this recognition of the cervix as an object of scrutiny within general practice, there was also flexibility concerning what to do about a cervix which presented no signs of abnormality.

There were also concerns within medicine that negative screening tests would mark a given population as healthy and therefore not in need of medical care. It was in an effort to get around this problem which directed arguments about who should have cervical smears. Within general practice there was an emerging tension between a desire to initiate a more widespread practice than already existed and concerns about ensuring compliance amongst women. One problem for general practice was the question of how to expand routine screening with limited resources. A compromise solution to this and to the issue of compliance,

⁶⁸ 'Eliminating Cervical Cancer' leading article in *British Medical Journal* 5 December, 1964: 1409

⁶⁹ RCGP, 1966, op.cit., p24

⁷⁰ Editorial 'Screening' *Lancet* 9 November, 1963: 987-988

was to focus screening on selective populations, on women who were thought to be at some kind of risk. Although risk was at this point an undefined category, general practice was clear that the new epidemiology would be capable of supplying answers to the question of 'which women?'.⁷¹ Gynaecology and pathology laboratories were already targetting women attending clinics, and for general practice these women signified women at risk. The very fact of their location within clinic boundaries underpinned their risk. Therefore, the same criteria were applied within general practice, and women seeking any kind of medical attention became by definition, women at risk.

However, practitioners were also concerned about the potential impact on the doctor-patient relationship which the screening of otherwise healthy women might produce. Wilson and Cantab, for instance, pointed out:

'Where a patient consults his own personal doctor, for whatever reason, it is easy for the doctor to make an investigation - e.g., take the blood-pressure - and keep his own counsel on what he finds. But if a "non-patient" is invited to attend for examination which he himself (not feeling ill) does not initiate, responsibility is incurred by the authority which has invited him and which finds something wrong. This responsibility may be transferred to the personal doctor in the form of a letter; the "non-patient" is asked to attend his doctor, and he now becomes a "patient". The situation will remain in hand so long as the doctor then knows what to tell his patient; but this may be very difficult in the case of some of the chronic diseases, of which borderline hypertension, diabetes, chronic glaucoma, and ischaemic heart disease have already been mentioned.'⁷²

It is worth noting the gendered nature of the language used here given that much of the active screening was directed towards women. The emphasis in this extract is on the nature of the doctor-patient relationship and the nature of the relations which connect them. First, where individuals initiate contact with their doctor, this was seen to support professional autonomy and preserve clinical judgement. Such contact entitled practitioners to a:

⁷¹ Freeman (1992) points to epidemiology as the 'toolmakers' of prevention.

⁷² Wilson and Cantab, 1963, op. cit., p52

'complete confidential access to a patient's person and private history.'⁷³

Such initiation assumes a degree of self-recognition of sickness, in classic Parsonian fashion (Parsons, 1951).

Second, there is an assumption of trust in this extract, in the sense that the doctor will have the appropriate knowledge and ability to deal with the problem identified by the patient, in the first instance. This could be seen as an expression of paternalism in the client-professional relationship but also an acknowledgement of uncertainty in the process of examination and interpretation. Where a patient does not initiate the contact him/herself, and where the individual is invited to make contact with the doctor, or health professional, boundaries of responsibility begin to shift. Where disease, or signs of pre-clinical disease, is detected, obligation is incurred by the authority, although this obligation may be 'transferred' to the personal doctor, bringing the relationship back into line, as the individual is reconstituted as a patient. This could be viewed as an expression of ambivalence over professional responsibilities and as an expression of anxieties about changes in the client-professional relationship. This is more fully articulated through the sense that the doctor may have little knowledge to pass to the patient about absence or presence of disease, particularly where the boundaries between absence and presence were contested boundaries. As the nature of 'expert' knowledge is undermined by diagnostic uncertainties space is opened up for questions by the patient, as the following extract suggests:

'Before populations are screened to find new patients, we ought to be clearer on what we can offer those who are found.'⁷⁴

Hence here is a perception of a shift in the client-professional relationship.

This view draws attention to tensions between prevention and intervention. On the one hand, increasingly screening was perceived as a

⁷³ RCGP 1966, op.cit.

⁷⁴ Wilson and Cantab, 1963, op. cit. p53

measure of preventing disease in the community. On the other, there were few ways of dealing with precancerous changes which did not involve unequivocal surgical interventions. Furthermore, screening which originated within gynaecology had the advantage of linking women immediately to a specialist with access to resources and hospital treatment facilities. Screening initiated by general practitioners simply served the purpose of demonstrating that abnormalities could be picked up with no immediate means of addressing them. Critics in gynaecology and within nursing focused on the absence of treatment and the potential sterilisation of young women and expressed concern about the unknown link between the effects of current forms of treatment and future fertility. Criticism also drew attention to the absence of information about the impact of screening on women and the absence of follow-up studies. Diagnostic testing for cervical disease initially emerged in hospital space and targetted clinic populations already under investigation and follow-up tests were rarely carried out. Where follow-up occurred, practitioners found it consistently difficult to persuade women to return for repeat smears,⁷⁵ and many women who were asked to return for follow-up smears, simply did not. This offended medical sensibilities and further raised issues of compliance, which had become a major focus in the inter-war period (Davidson, 1993). Non-compliance, or default from medical care and treatment was increasingly seen as a waste of public funds and a practice which compromised efforts to deal with threats to womens' health, particularly those initiatives, such as screening, which were associated with cost reduction.

Risk and Recruitment

Medical debates in a range of journals suggest that a key problem which practitioners identified was that it would be difficult to mobilise people who thought themselves to be well, to submit to a diagnostic test which

⁷⁵For instance, one study observed that of 67,071 smears taken from women in Jefferson County, Kentucky, 776 smears were unsatisfactory and 253 women were known to have previously diagnosed carcinoma of the cervix. Of the 66,043 women remaining in the study, 883 required biopsy after the smear report (13%). After one year, only 26,913 women returned for screening (40% of the entry group). This was apparently in spite of "an intensive propaganda programme". Christopherson, W.M., Parker, J.E., Drye, J.C. 1962 *J. Amer. Med. Ass.* cited in 'Cytology of the Cervix' *Lancet* 2 March, 1963: 482-483

might reveal otherwise. This perception was bolstered by the knowledge ambiguities embedded within interpretive debates, which, if presented to patients, would deter rather than secure compliance. A critical issue, not peculiar to cervical screening (see also Arney and Bergen 1984), was, therefore, the problem of how to instil the notion in healthy women that they would not remain healthy if they did not comply with an emerging regime of surveillance. One counter strategy to minimise this problem, was the identification of specific populations whom, it was thought, would respond obligingly to screening and yield justificatory results. Epidemiology played a crucial role here, as in other cases of prevention, in the identification of such populations. Therefore the medical establishment were reluctant, early in 1963, to straightforwardly sanction widespread use of diagnostic testing as a form of general population screening. However, later in 1963, a leading article in *Lancet* more clearly advocated the development of screening for 'certain specific abnormalities'.⁷⁶ In part, this was associated with the way in which, during the mid to late 1950s and early 1960s, professional discussion began to focus on the causes of cervical disease. Prior to this, public discussion in the pages of journals such as *Lancet*, *American Journal of Obstetrics and Gynaecology* and the *British Medical Journal* were seldom around the causes of cancer.

Whilst it was still acknowledged that individuals usually became patients by initiating contact with doctors themselves, on the basis of self-recognition of sickness, a more blurred distinction between wellness and sickness was acknowledged. There was, at this point, a sharper sense that individuals may be unable, in a variety of circumstances, to make this judgement themselves. Therefore, there emerged an urgency to the debate around screening, which mobilised a need to eliminate self-recognition and judgement as the basis for the initiation of contact between individuals and professionals. Prevention, and the detection of pre-symptomatic disease, played a crucial role in this gesture toward elimination.

There were available repertoires for targetting selected populations for

⁷⁶ Editorial 'Screening' *Lancet* 9 November, 1963:987-988

screening.⁷⁷ Syphilis testing had become routinely practised in the interwar period amongst those women who were mothers, through routine ante-natal testing for syphilis (Tait, 1974; Davidson, 1993). The targetting of women in the context of motherhood was therefore already an available repertoire in the emerging preventive discourse (Graham, 1979). Furthermore, targetting selected populations for the detection and treatment of disease was becoming routinised through other techniques such as mobile X-ray vans and BCG vaccination schemes in the 1950s. Women were recruited for smear-taking in other ways: through hospital clinics which had the effect of recruiting reproductive women between the ages of 15 and 24 who participated in ante-natal care. More explicit recruitment drives in local communities, such as in studies funded by the British Empire Cancer Campaign and through general practice also generated recruits. In Edinburgh, women attending gynaecology and ante-natal clinics were subjected to a cervical smear along with the other examinations and investigations being carried out (Tait, 1974). Recruitment drives focused on local communities and enlisted the support of women to persuade other women to participate in screening.

Women were often drafted into an army of field workers (Patterson, 1987), who might enlist other women and persuade them to submit to a smear test. In Scotland, women were identified by Health Visitors in the 1950s, through school children, or by trained fieldworkers who were prepared to persuade other women to participate in diagnostic testing. Similarly, in 1952, the Mother's Welfare Clinic in Edinburgh, in collaboration with the university department of Obstetrics and Gynaecology, undertook cytology testing of smears taken from all women attending their clinics (Tait, 1974, p167). Nurses and health visitors were identified as professionals who might legitimately enter the homes of women as a way in reducing the costs of screening and acquiring access to working class women in

⁷⁷ Tilley (1984) refers to repertoires of social action in relation to twentieth century collective action. I suggest here that the concept is a useful way of thinking about the management of screening by targetting selected populations. Although many general practitioners and gynaecologists favoured widespread population screening, resources and organisation prevented this. Practitioners were, however, able to draw on readily available repertoires which had been deployed in relation to other kinds of screening, also oriented towards women, and which could be directed towards specific groups.

particular. Working class women were seen by some general practitioners as inarticulate and resistant to medical intervention and therefore unlikely to attend for screening.⁷⁸ Other means of recruitment included the possibility of distributing cyto-pipettes to every home with instructions for use. The *British Medical Journal* observed that the Davis cyto-pipette could be distributed to the homes of women who would not attend their general practitioners for screening in order to increase compliance. However, this was also perceived as radical and as undermining the role of general practice,⁷⁹ in contrast to Papanicolaou who had encouraged women to take their own smears, albeit under hospital jurisdiction.

Although smears were principally taken from women attending clinics in the 1940s and 1950s, risk categories were also developing and expanding. Women were seen as biologically at risk of cervical disease in the 1940s and the female body was, in certain instances, seen as predisposed to 'exciting' factors, such as injury, oestrogen or infection, which was seen to produce cervical cancer. Similarly, ideas about selected populations, or populations at risk, were already in circulation in relation to age and parity. Older women and women with a number of pregnancies were initially identified as being at risk from developing cancer, although this identification was not initially linked to sexual activity. However, in the 1950s, risk was increasingly associated with marriage and fertility, which implied sexual activity, as published work observed a higher number of cases of cervical cancer, and higher mortality rates, amongst married women.⁸⁰ In 1953, F. W. Gagnon demonstrated the absence of cervical cancer amongst a sample of 222 Canadian nuns over a twenty five year period,⁸¹ a finding which was further underpinned by a statistical association between recurrent 'instability' of cervical epithelium, early marriage and multiple pregnancies. During the early 1960s, a number of papers developed these observations and pointed to the relationship

⁷⁸ MacGregor and Baird, 1963, op. cit.

⁷⁹ Leading article 'Cervical Cancer: Early Diagnosis or Prevention?' *British Medical Journal* 22 May, 1965: 1327

⁸⁰ Logan, W.P.D. 'Marriage and Childbearing in Relation to Cancer of the Breast and Uterus' *Lancet* 5 December, 1953: 1199

⁸¹ Reported at the *Conference for Clinical Pathology and Geographical Pathology* in *Lancet* 25 September, 1954: 653

between cervical cancer and coitus,⁸² in particular, 'early age of first coitus', 'extramarital relations', and 'frequent coitus at all ages'. A range of other possibilities which such work identified, included, a virus and penile hygiene.⁸³ Therefore medical debate increasingly pointed to the need for 'targetted screening' of those 'at risk'.

A number of contributing factors to the development of cervical cancer were identified. These included social class, ethnicity, marital status, age at marriage, the number of sexual partners, the form of contraception, smegma and circumcision. These factors were reflected in Scottish practice which, in theory, extended screening to all women in 1965 but prioritised married women and women given vaginal examinations as high risk categories. For instance, a *Lancet* editorial declared:

'...if a girl is old enough to have a vaginal examination she is old enough to have a cervical cytological examination.'⁸⁴

Because of the issues raised around responsibility for patients, those supporting screening within general practice were keen to limit screening to certain categories of women for whom it was thought a risk of developing cervical cancer might be greater (and presumably the possibilities of detecting abnormalities might be greater). Furthermore, the creation of risk groups, principally around marital status and age, could be interpreted as a way of controlling resources, and expanding surveillance. The primary problem was getting around the problem of ensuring that women who considered themselves well, as potentially diseased.

Definitions of sickness became increasingly problematic for medicine and differentials in the point at which people recognise a need for medical attention were recognised as limitations in relation to presymptomatic investigations. How could medicine get around the problem of getting

⁸² A number of studies are identified in *Lancet* 28 November, 1961: 211, but of particular importance is that by Terris, M., Oalman, M. 1960 'Coitus as likely cause of cervical cancer' *Journal of American Medical Association* (174): 1847

⁸³ Discussed at the *Third World Congress of the International Federation of Gynaecology and Obstetrics* in Vienna, 30 September, 1961.

⁸⁴ Reported in *Lancet* 2 March, 1963: 483

people who felt healthy to surrender to periodic health checks and screening tests? Here we find a more or less explicit focus on the puzzling issue of compliance. How could medicine persuade the population that it might be valuable in personal terms to have latent disease detected and corrected? At the same time, it was clear that medical discourse acknowledged the irrationality of seeking attention when feeling well. This conundrum, of finding a way to institutionalise screening and rationalise seeking attention when well, was, to a degree resolved through risk categorisations and the mobilisation of social duty, in which women were incorporated into the surveillance of other women.

Conclusion

The material I have presented in this chapter reflects professional debate on changes in medical culture and highlights professional discussion of local practices. It is therefore limited in the extent to which it can be used to develop a social history of screening or indeed, a sociology of scientific knowledge in relation to screening. Nevertheless, I suggest it has sociological value. I have used the material to highlight discursive shifts, and their continuities and disruptions, to suggest that prevention, as a form of surveillance, was initially underpinned by diagnostic testing and the detection of disease in acute specialisms such as gynaecology. The movement of screening into general practice and community medicine, was accompanied and shored up by a discourse of prevention, in which the notion of pre-symptomatic disease became increasingly significant.

The detection of cervical disease, was first oriented towards clinic populations, through the specialism of gynaecology. Those who supported smear-taking did so on the grounds of its utility for case-finding, whilst those who rejected its utility did so on the assumption that dependence on laboratory medicine would undermine clinical autonomy. The smear and the practice of smear-taking henceforth developed as an entry point into a wider network of surveillance. As smear techniques were refined, and classification systems developed, which identified cervical disease as a complex, non-linear process (Clarke and Caspar, 1991a), smear-taking expanded into community populations. Perceptions of background prevalence, the institutionalisation of multiple screening in American public health and the increased potential for case-finding, further

underpinned this expansion in British medicine. Cervical screening has become entrenched as a practice which eradicates normal and abnormal cells. The relaxation of pathological criteria and changes in classification have underpinned the growth of particular forms of therapeutic intervention, such as colposcopy.

However, the expansion of cervical screening, as an instance of surveillance, has not occurred through the exercise of sovereign power. On the contrary, the power relations governing this expansion have been incorporative in the way that other professional groups have been drawn into the rubric of screening. However, the expansion of smear-taking and its redefinition as screening, generated new concerns around the institutional location of patients and recruitment. General practice focused upon recruitment as a critical issue to ensure its own relationship to other institutions, such as local authorities and the acute sector, as well as to shore up compliance.

Recruitment into cervical screening began to deploy the language of risk, in which particular categories of women were specified and identified, many of whom were already part of a clinic population. Women attending ante and post-natal clinics; women recruited through other professional groups such as health visitors and nurses or through mother and child clinics, were seen to embody compliance. As screening became an increasingly routine aspect of general practice, sexual status and activity became the focus for the development of risk categories. These have expanded to include not only women who are identified as members of particular categories (married women) but all women who are identified as (hetero)sexually active, to which I return in the following chapter. Hence the identification of risk categories was perceived, to some extent at least, as a solution to the problem of compliance, and we can therefore see knowledges of risk as a *product* of surveillance.

The generation of compliance, the engendering of risk and their relationship to issues of knowledge and interpretation are recurring themes within the story of cervical screening. Therefore, the expansion of cervical screening must be seen in a context of an increasing emphasis on diagnostic testing and its transformation into prevention; the

development of services for particular populations, such as women; and the extension of health throughout the population with the emergence of the welfare state. I have argued, however, that the female body has been identified as a particular object of scrutiny for the presence of disease, and the development of screening should, therefore, also be seen as a gendered project, which I will now discuss in more detail in Chapter Four.

CHAPTER FOUR

CERVICAL SCREENING, HEALTH AND CITIZENSHIP

The Prevention Paradox

Introduction

In this chapter I place cervical screening in the contemporary context of prevention and pick up on themes of cervical screening described in the prologue. I will do this, first, by conceptually locating cervical screening through a discussion of the connections between prevention, health and citizenship. Second, I will introduce the ways in which screening is represented and how such representations address women. Finally, I will outline current policy issues and the ways in which social science has addressed screening, in order to illustrate its status as part of the 'prevention paradox' (Rose, 1985).

With few exceptions (Burrows, Nettleton and Bunton, 1995; Scott and Freeman, 1995), sociology has yet to critically address the power of prevention and the contradictions and interventionist strategies which calls for prevention demand (Turner, 1987). Furthermore, whilst there is a more critical literature addressing issues of prevention and HIV, there has been little more than passing reference to prevention in relation to cervical screening (Armstrong, 1995; McKie, 1996). Prevention has been a key theme within twentieth century medicine, linked, importantly, to power and state legitimation. In turn, the state has supported the role of medicine in policing a social and moral order through public health and social medicine (Wear, 1992). Prevention is, however, somewhat paradoxical and reveals the complexity of relations between the body, gender and health.

Prevention emerged as a dominant theme governing the development of general practice and primary care in the 1960s (Davies, 1984) and was consolidated as a key policy strategy in the 1980s. The shift towards prevention has increasingly been an aspect of health policy, not only in Britain, but also in Western Europe (Allsop and Freeman, 1993). Government white papers and consultative documents such as *Prevention and Health: everybody's business* (DHSS, 1976), *Promoting Better Health* (DHSS, 1987), *Working for Patients* (DoH, 1989a) and *General Practice in*

the National Health Service: the 1990 Contract (DoH, 1989b) bear witness to the ways in which prevention has been formulated within health policies and has come to be central to the practice of both health education and promotion.

Prevention has been identified as a symbolic goal, embodying the notion of social citizenship (Freeman, 1992), and as a means of rationalising resources (Murcott, 1979; Taylor, 1982), in response to shifts in epidemiological patterns of disease and demographic changes, in which industrial societies are characterised by long-term chronic diseases and increased life expectancy (McKeown, 1968). Prevention can be also be understood as a gendered form of work, undertaken in private (Graham, 1979) and as part of a wider apparatus of social control (Lewis, 1986), particularly through population screening, in which the role of the state has expanded. Preventive strategies, such as those embodied by cervical screening, illustrate the following paradoxes of citizenship.

The notion of personal choice, lifestyle and responsibility has been the dominant focus of attention for sociology in relation to prevention. The focus of prevention and screening on well-being requires continuous intervention in populations which have not been defined as sick. Individuals are increasingly encouraged to take responsibility for the maintenance of their own health through procedures such as blood pressure monitoring and cervical screening, institutionalised as 'well man' or 'well woman' check-ups. Screening is, thus, located within explicit and implicit agendas of individualised care which potentially shifts responsibility for the production and maintenance of health from the state to the individual (see, for instance, Bunton, 1992). The labour market is also a context for screening practices and some employers, such as the *Post Office* in the late 1980s,¹ and retail firms such as *Marks and Spencer*, offer a variety of screening tests as part of a package of benefits. A prevention paradox can be seen in this example. Screening procedures in the context of employment, may offer protection for individuals as workers, but monitoring the workforce can also be seen as a form of

¹ A new employee initiative was reported in the *Daily Mail* 4 August, 1988, p9, in which women employees were offered cervical screening by an all woman team.

protection for employers (Lupton, 1994). Whilst such screening is rarely compulsory, in that it is left to personal choice, it is, nonetheless, tacitly assumed that individuals will comply (Greco, 1993).

In addition, prevention has been introduced into public discussion of the individual management of health. Both the broadcast and print media regularly run articles which address ways in which individuals themselves can contribute to the prevention of disease and ill-health through behaviour and attitude modification. The media have claimed a particularly influential role in the dissemination of information, which health agencies deploy in an attempt to utilise popular culture (Backett and Davidson, 1992). In 1995, for instance, the *Health Education Board for Scotland*, employed a strategy of billboard advertising in a campaign designed to advocate fruit as a healthy snack, in place of sugar laden foods. As is increasingly recognised in academic and non-academic contexts, the media has a significant role in rendering health issues socially visible, and, more importantly, as amenable to personal choice.

Hence the experience of health in late modernity is mediated not only through medical practices and knowledge, but also through initiatives which are endorsed and underwritten by both the state and the market. The latter are often couched in terms which draw on notions of choice and consumption opportunities, and are represented as offering the individual more control over his or her life in relation to health, through knowledge and information sharing. Indeed, individuals may have access to more information about their health, in the context of screening. In this way, individuals may be able to exercise choices over treatment and interventions, and be encouraged to participate in decision-making processes in relation to such interventions. Access to information potentially underwrites the possibility of critical engagement with the management of one's own body and health.

Yet, screening may also contribute to the creation of knowledge uncertainties, or provide individuals with more information than they are able to process. Screening data, for blood pressure or cervical disease, produces and records data for laboratories to process; for general practitioners and specialists to make judgements upon; and for individuals

to assimilate, comply with or challenge. Similarly, practitioners have raised concerns around the ethics of screening and the implications of quotas for general practice.² For example, debates in the medical press have focused on the coercion implicit in the quota system to which cervical screening is pegged and the ways in which this may lead some practitioners to remove those women from their lists, who are thought unlikely to participate in screening.³ Other aspects of such debate have focused on the issue of screening particular categories of women, such as those with learning difficulties,⁴ where the tension between choice and care is at its most acute. Hence, within the expansion and experience of screening, as a key procedure in the prevention of disease, issues are raised about the potential for tension between citizenship and surveillance, and the different ways, individual and/or collective, in which these are embodied.

The prevention paradox is perhaps most clearly embedded within cervical screening. The routine examination of the cervix, to detect cell changes indicative of malignancy, has been an implicit aspect of health care in many European and Nordic countries, as well as North America, since the mid 1960s. This kind of extensive observation produces and accumulates knowledge concerning the bodies of individuals. Routine screening programmes require central coordination through computerised databanks to provide access to increasingly expansive categories of women. The centralisation of such data, though aiding the call and recall of women for cervical smears, normalises screening participation, but in doing so, underpins claims to social citizenship. Paradoxically it yields greater intervention on the part of medicine, institutionalises expert observation over women's lives, and arguably expands indirect control over the linguistic and metaphorical bases on which knowledge and experience of the body rests (Posner, 1991). This raises questions about the implications for the status of knowledge in women's lives.

² This point is made by the General Medical Services Council 1989 *Report to a Special Conference of Representatives of Local Medical Committees* on 27 April London: British Medical Association

³ Chisolm, J.W. 1990 Comment *British Medical Journal* 300: 853

⁴ Haire, A.R., Bambrick, M., Jones, J. 1992 'Cervical Screening for women with a mental handicap' *British Journal of Family Planning* (17): 120-121

Within neo-liberal conceptions of citizenship, individuals are expected, as citizens, to exercise choices in ways which will affirm their responsibility for their own lives and well-being. The market has a key role here in the provision of a range of 'lifestyle checks' which imply a degree of choice for individuals. Whilst the state is not formally expected to intervene to ensure such well-being, preventive strategies such as cervical screening, are associated with quotas and targets which those who are responsible for their delivery must fill, in order to attain their own remuneration. Hence within the neo-liberal version of citizenship embedded within prevention, the boundaries between the market and the state are blurred, since indirect coercion in the form of quotas is articulated through a discourse of individual 'choice'. In contrast, social democratic versions of citizenship emphasise the role of the state in ensuring well-being and place emphasis on collective responsibility for the control of disease. At the same time, however, the social democratic approach embedded within a preventive strategy such as cervical screening, engenders greater degrees of self-surveillance in the maintenance of individual well-being in ways which obscure the social origins of disease. Therefore a paradox arises from these different notions of citizenship, traces of which can be found within the project of prevention, and hence cervical screening.

Prevention, feminism and citizenship

There are close links to be made between citizenship, prevention and feminism. The social democratic model of citizenship associated with T.H. Marshall (1963), whilst criticised for its gender blindness (Lister, 1990), its ethnocentricity (Solomos, 1989) and its failure to identify the historically uneven development of citizenship (Mann, 1987), has, nevertheless, been critical to sociological understandings of contemporary rights and obligations. Furthermore, Marshall acknowledged the extension of rights and obligations to women as part of the more general expansion of citizenship pertaining to his model. This 'extension' has been nowhere more critically engendered than within the development of the welfare state.

In Britain, liberal feminism has been implicitly critical of the welfare state and the intervention into personal lives on which it is premised, through agencies such as medicine and social work, placing emphasis

instead, on autonomy, self-determination and choice. Yet, women have been both integral and instrumental to the development of the welfare state (Wilson, 1977) although the experience of being welfare citizens may be both different and contradictory (Marshall, 1994, p134). As Hernes (1987) has argued in relation to the Scandinavian model of welfare state citizenship, even where women have not been the 'power brokers' in the development of citizenship, nevertheless, gender has been central to its development. Hence, the welfare state can also be understood as a feminist project, as the guarantor of social rights in the public sphere or at least, as a 'feminised' project in which principles of 'care' are embedded (Gilligan, 1982; Holmwood, 1993; see also Walby, 1995, for a recent critique of the shift from private to public patriarchy and the role of the 'feminised' welfare state in this shift). Hence, the development of social citizenship and feminism can be seen to be closely linked through the expansion of welfare and the provision of health care.

This link is further integrated through prevention. Many preventive strategies developed since the mid-twentieth century have both directly and indirectly addressed female subjects, in ways which express the moral project of the state (Marshall, 1994). As Pateman (1988) suggests, women have been incorporated into citizenship in different ways, and within the expansion of prevention, women have been identified as particular subjects. In relation to issues of health, the liberal state is most often seen as the guarantor of entitlements in terms of access to care and the provision of information. Within and through prevention, women are differentially marked out as mothers and guardians (Graham, 1979; Nettleton, 1992), and as carers in the community (Armstrong, 1983; Finch and Groves, 1983). Moreover, women are addressed as watchers over both themselves and others (Stacey, 1988).

Therefore, the welfare model of citizenship which has prevailed in Britain has been a gendered model, in the sense that whilst citizenship has been clearly expressed through social rights for women, at the same time, the social contract implied within the welfare model of citizenship has placed emphasis on obligations which express bonds of membership. As Turner (1990) has observed, this relationship raises questions about the nature of entitlement in relation to gender. On the one hand, the welfare model has

articulated a material basis to citizenship, through rights of access for women to the provision of health care. On the other, the state has implicitly addressed female citizens as informal providers of care, and placed emphasis on their social obligations to do so. Through this identification as care providers, women potentially experience greater regulation and therapeutic surveillance, through preventive programmes, for instance.⁵

It is against this that the notion of empowerment has often been mobilised in both theoretical and substantive areas of feminist debate. Empowerment is mobilised in feminist argument as a resource on which women may draw in order to challenge medical knowledge or state interventions. Embodied experience is often drawn upon here as the source of empowerment, which is most clearly articulated within a liberal discourse of rights (Morgan and Scott, 1993). Within a liberal version of citizenship, empowerment is often equated with the 'right to choose' in ways which position women as informed consumers. However, the notion of empowerment, and the language of choice upon which it draws, also assumes a consensus around the social good of preventive strategies such as those embodied by cervical screening. Here, opting into prevention would be seen as empowerment, as exercising entitlements, in contrast to other ways of interacting with prevention, such as opting out.

The provision of information has been seen as crucial for female empowerment, as a way of enabling women to challenge conventional medical wisdoms and make 'informed' choices about the kinds of health care they desire. The development of well woman clinics in the late 1970s and health promotion in the early 1980s is a critical moment which signals the move to a liberal empowerment model within the provision of health care. Such a move was in part, as feminists have argued and as I reviewed in Chapter Two, a resistance to medicalisation and a commitment to redefining health in terms which also took into account the division of labour in which female embodied experience is located. However, such a move also highlights the importance of social position and the

⁵ It is interesting to note how recent screening initiatives directed towards men mobilise a language of care. For instance, 'health check-ups' and 'MOTs' offered within private medicine utilise a notion of care, which is, significantly, located within the public domain.

relationship of the body to social position. As Crawford (1980) and Ehrenreich (1983) suggest, such a move can also be seen as a mechanism through which the new urban classes were able to feel empowered in the arena of health, where power was absent in other dimensions of political activity. As individual participation in the broader political process has become increasingly difficult, and in which the body has been subject to privatisation and compartmentalisation, an unintended consequence has been the shift to 'healthism' (Crawford, 1980). In such a shift, whilst people become producers of their own and others' health (Stacey, 1988), in ways which preserve the liberational possibilities inherent within the discourse of 'empowerment', they also do so in ways which might be read as expressions of internalised surveillance. Paradoxically, therefore, welfare states both regulate social life, through the production of certain obligations for instance, *and* provide the material basis for social citizenship.

Cervical screening, as an aspect of prevention, can be located within this set of arguments about gender, health and citizenship. The development of screening should be set in a wider context of an historical transformation in professional-client relationships, which, in turn, charts the birth of the welfare state. From the mid-nineteenth century to the inter-war years of the twentieth century, such relationships were governed by trust, paternalism and compliance. The early development of cervical screening, outlined in Chapter Three, illustrates these assumptions, now institutionalised in the 1990s by the state, through the recent introduction of quotas and target setting within general practice. They are further underpinned in critical feminist discussion of cervical screening which upholds a commitment to the project of screening. Feminist discussion implies a relationship between empowerment and participation and fails to acknowledge both non-participation as agency and other expressions of agency within participation.

In part, this arises because the perceived simplicity of cervical screening may be sustained through relations of trust (Giddens, 1990), in which women are positioned as clients within a professional/client model of relationship. As Parsons (1951) argued, within this relationship, trust enables clients to permit professionals to do whatever is necessary to

restore them to health and to enable them to meet their social obligations. A key difference in this relationship, however, is that in the case of cervical screening, as practitioners themselves acknowledged in the 1960s and to which I drew attention in Chapter Three, clients do not autonomously seek out medical practitioners in response to bodily ailments or change. Rather, clients may or may not *respond* to requests from practitioners to participate in examinations and investigations which are premised on identifying indicators of disease. That is, individuals are invited to participate in the production of knowledge around their own health status. Furthermore, through the introduction of market principles into health care, citizens are encouraged to seek out information and exercise choice over health related behaviours and practices. As Sontag (1989) has noted in relation to HIV antibody testing, such practices raise the possibility of a new class of the 'future ill'. There is, therefore, a fundamental tension here in preventive discourse, between neo-liberal and social democratic notions of citizenship.

The new context of self-surveillance embedded within neo-liberal versions of citizenship raises key questions about the nature of professional-client relationships, the experience of trust and the production of risk. Indeed, the case of cervical screening can be used to examine the production, maintenance and negotiation of a series of tensions in late modernity: between the state and civil society; surveillance and citizenship; authoritarian and liberal discourse. In particular, the case of cervical screening demonstrates the ways in which participation in preventive strategies is *normalised*, or, the non-coercive techniques which encourage individuals to voluntarily govern their own conduct in ways which meet the objectives of health (Rose, 1990).

However, the conceptual location of cervical screening within a neo-liberal discourse of prevention, in which information and autonomy are linked, has deterred critical engagement of the social relations in which screening is located. Cervical screening, like breast screening,⁶ differs from other screening initiatives in the sense that it is focused solely on the female body, and therefore addresses particular subjects. This can be interpreted as preferential treatment, for instance, recent media

⁶ See Hann (1993) for a recent critical discussion of breast screening.

discussion has drawn attention to the absence of screening programmes exclusively addressing male complaints, such as testicular or prostate cancer, and addressed this absence as an issue of gendered inequalities. Yet such debate also highlights the status of the female body in post-war health activism, and the way in which feminist focus on the particular experiences of female embodiment have been critical to the development of the welfare state. Feminist attention to the female body has been central to the expansion of social rights through the provision of health care which, in turn, has helped to secure participation in the labour market by the removal and modification of what have been both perceived and socially shaped as bodily constraints. Cervical screening, therefore, must also be placed in a wider context in which screening more generally, as an expression of prevention, is understood as a gendered project, which also represents authoritarian notions of citizenship.

As I outlined in Chapter Two, aspects of this health care, such as medicine, have been subject to feminist critique. Medical culture has been seen as instrumental in the social control of women and the female body through language and technologies such as hormone replacement therapy, tranquilizers and reproductive technologies. In response to mechanistic health care systems, perceived to be morally directed towards the social control of women, a key strategy has been the self-help movement, which advocated self-knowledge and care as a means of challenging the masculinist, medical mode of practice (Lewin and Olesen, 1985). Feminists have argued that the key to establishing power over one's self is the establishment of power over one's material body. Yet within debates on the status of the female body in civil society there are considerable tensions between the potential for autonomy and social control through self-knowledge. This is evident in the case of cervical screening. Prevention has therefore been seen as a solution to medical power but more recently it has been argued that it should also be seen as a problem of modernity (Scott and Freeman, 1995) and as a form of surveillance which contributes to social regulation (Hastie, Porch and Brown, 1995).

Public discussions of cervical screening, and social science research agenda, have largely adopted a normative position *vis-a-vis* cervical screening, which has reinforced the importance, and defined the

parameters of participation. Embedded within prevention discourse are issues of social participation, which are articulated through the nature of information about screening, the provision of screening and the notion of consumer choice with which it is increasingly associated. Female subjects are addressed in terms which place responsibility on them for the prevention of *potential* disease, located within specified bodies, identifiable through diagnostic tests which are thought to reveal such potential within particular bodies. The moral project of prevention lies both in its emphasis on individual responsibility and its demand for compliance. Professional and political anxiety over default from participation in prevention, reveals the tensions between obligation and entitlement, between an authoritarian and liberal approach to health (Scott and Freeman, 1995). These tensions are reproduced in feminist approaches which place emphasis on empowerment, but in doing so normalise compliance and locate non-participation as deviance. Such a gesture silences the diversity of experiences of screening and the contradictions, ambiguities and ambivalences embedded within.

Normative assumptions about obligation can also be identified within feminist discourse on women's health, particularly those which emphasis empowerment and entitlement as a political strategy for redefining health care in line with female embodied experience (for instance, Lewin and Olesen, 1985). By the late 1960s and into the 1970s, the cervical smear was perceived by many as a key entitlement which women could, and should, claim from the state. In a pre-quota era, the smear test could be read as an identity marker, as a mark of sisterhood. The cervix was explicitly marked out and politicised by the women's health movement in North America (see Ruzek, 1978). Visualisation was identified as a key empowerment strategy which would enable women to 'own' their cervix, as a basis for establishing challenges to medical knowledge and practice. Whilst cervical self-examination did not become an entrenched self-help strategy within British female society, nevertheless the cervix was still marked out within feminist discourse as a site of contestation through texts such as *Spare Rib* and *Our Bodies Ourselves* (Phillips and Rakussen, 1971).

Indeed, self-help groups, such as the *Cervical Screening Campaign*, in parts of Scotland, encouraged women to challenge medical culture, and much of the social science research in the 1990s draws on a similar set of assumptions (Posner, 1991; Schwartz, Savage, George and Emohare, 1989). Hence, feminist discourse also places obligations on women to participate in screening, to embrace notions of empowerment and make entitlement claims on the state. Therefore, there is considerable potential for overlap between notions of obligation, entitlement, empowerment and self-care (Crawford, 1979; Rose, 1990). Empowerment and obligation are intertwined within feminist discourse, and are mobilised through liberal ideas about choice and entitlement. The material presented in Section Three raises the question of whether notions of empowerment and entitlement encourage women to make claims on the state, or whether they take their force from the ways in which the obligation of participation, and the risks of non-participation, are internalised.

Cervical screening is therefore critical to debates around surveillance, self-surveillance and citizenship. Located within a preventive discourse, it is associated with the production of 'health' for individuals, and is also associated with issues of inequality and access to health care. The articulation of health promotion within feminist discourse encourages women to assume responsibility for their health, by participating in screening programmes. For women, however, this is often ambiguous. It may, potentially, affirm social membership through conformity to normative standards. However, to assume responsibility for one's health, for instance, by having a smear test, demands that individuals place trust in expert knowledges and practices, and disregard their embodied experience. At the same time, women are encouraged to challenge aspects of the process which continue to be problematic (Posner, 1991), such as ambiguous language and information. Women are encouraged to demand information through which choices can be exercised, and this is reinforced by the language of empowerment and entitlement deployed by prevention professionals. Thus, crucial to prevention discourse, is the investment of trust in expert knowledge and the system in which cervical screening operates. Yet, to acknowledge knowledge ambiguities and procedural problems, throws trust in expert knowledge into question (Giddens, 1991).

Therefore, whilst cervical screening is represented as a social entitlement, it is also located within a context in which the state has increasingly endorsed the notion of individual responsibility for health and correspondingly disease. This raises issues concerned with the nature of social obligation in modernity and claims to entitlements which members of society might make on the state and upon expert knowledge. What precisely might such responsibility entail for women participating in screening initiatives, and what are the social implications for failed responsibility? The notion of the individual mobilises a language of rights and citizenship, and debates over access to cervical screening and agitation for its routinization also mobilise the concept of citizenship. This forms part of a repertoire of social action derived from a fusion of self-help and the women's movement. Hence, cervical screening offers a site of contestation organised around the female body and its location between surveillance and citizenship. The following discussion will illustrate this argument in two ways. First, I discuss how screening is represented to women in information literature and the media, and how women are identified within this representation. Second, I outline current policy and technical concerns and how issues of compliance, or obligation, entitlement, risk and trust are implied.

Representing Screening

The familiar story of cervical screening is largely written and represented as a triumphant history of scientific and medical progress. The 'cervical screening programme' is represented within the public domain as a co-ordinated programme of primary health care and secondary prevention and the smear test itself is represented as simple, straightforward and painless. Information leaflets emphasise the simplicity of screening and stress normal outcomes. For instance:

'The cervical smear test shows changes in the cells on the cervix or neck of the womb.'⁷

'Cervical smear tests spot pre-cancer which can almost *always* be treated successfully.'⁸

⁷ Posner, T. 1987 *An Abnormal Smear: what does that mean?* Women's Health Information Campaign Fact Sheet No. 2, London

⁸ Lothian Health Board publicity leaflet, 1988

'The purpose of having cervical smears at least every three years is to detect abnormal cell changes at a stage when they cause no symptoms, can be treated easily, and before they develop into a serious condition.'⁹

'[The cervical smear test] is an early warning test which shows if there are any changes in the cells of the womb (cervix) which might develop into cancer.'¹⁰

'The aim of a cervical or 'Pap' smear is to detect...abnormal cells before they progress to become cancerous.'¹¹

This representation of cervical screening as unambiguous has the effect of 'black boxing' (Singleton, 1995), in the sense that cervical screening is sealed off from further critical examination. Furthermore, women are addressed in such literature in a limited number of ways. For instance, one leaflet introduces screening by asking 'why won't you have your cervical smear test?'.¹² This leaflet uses a question and answer format to draw attention to reasons which women may point to for not having a smear test, and responses to them. These questions highlight the forms of knowledge which women may draw upon to legitimate their objections to screening, for instance:

'I feel fine - I don't want to know.'

'Since there is no cure for cancer, I don't want to know.'

'I don't need the test, I am not promiscuous.'

'My doctor is a man. I would be embarrassed.'

Information leaflets respond to these questions in two ways. First, they provide factual information about the smear test and what screening involves, as a counter to statements which are identified as irrational, albeit understandably so, but nevertheless perceived as statements of ignorance. Second, responses redefine the identity of those asking the

⁹ Women's Health Information Campaign Fact Sheet No. 2 op.cit.

¹⁰ Women's Nationwide Cancer Control Campaign 1989 *Cervical Smear Test: when did you have your last test?* London

¹¹ Doyal, L. no date *Women's Health and Cervical Cancer* London: Women's Health Information Campaign, London

¹² *Why won't you have your cervical smear test?* (no date) Women's Nationwide Cancer Control Campaign, London

question and suggest ways of modifying behaviour. Women are repositioned in a number of ways, for instance, as 'well women':

'The smear test is done when you are well. The idea is to keep you feeling fine.'¹³

Or by redefining all sexual activity as potentially risky:

'All women between the ages of 20 and 64 who have *ever* had sexual intercourse need regular smear tests.'¹⁴

Attention is drawn to both specific and general risks by highlighting potential causal factors such as smoking, having 'sexual relationships' with more than one partner, or pregnancies at an 'early age'. Neither 'sexual relationships' nor 'early age' are clearly defined in this information literature. In addition to the identification of 'risks' associated with cervical cancer, this literature draws attention to the fact that absence of symptoms is not an indicator of the absence of disease, thus emphasising a more generalised dimension of risk. Time is the focus of attention here because of the possibility that 'pre-cancerous' cells may take many years to develop into cancer.

Women are also addressed as carers and kin. For instance, one leaflet asks:

'Have your mother and grandmother had a smear test?'¹⁵

The flow of information here assumes relations in which first, there is a relationship of care between female kin, and second, that the direction of care flows from daughters to mothers. This is further underpinned by the nature of the information which then follows about the development of pre-cancerous cells amongst women over fifty. This draws attention to chronological age as a risk factor and suggests:

¹³ Doyal op.cit.

¹⁴ Policy in England and Wales advocates screening for women between 20-64. For women in Scotland, screening is advocated for those between 20-60 years of age.

¹⁵ Women's National Cancer Control Campaign, no date, *Have your mother and grandmother had a smear test?* London

'When the older members of your family receive their invitations - do make sure that they go and have a test.'¹⁶

Women are asked here to redefine themselves as lay enablers, encouraging older women to identify themselves as 'older' women and accept a need for screening. This need is developed by drawing attention to the possibility of pre-cancerous cells developing at any chronological age and again, emphasises generalised, rather than specific, notions of risk. Information leaflets addressing both prevention in general and the management of clinical encounters in relation to screening, point to behaviour modifications as a way of redefining identities in ways which smooth the path for regular cervical screening. Women are told to stop smoking; to have a smear test regularly; to consider the use of barrier methods of contraception in sexual relationships; to wear clothing which will minimise exposure to reduce 'embarrassment' during the examination. The tenor of this kind of information mobilises an authoritarian notion of prevention, which emphasises the responsibility of individuals to contribute both to their own health and well-being, and that of other women, such as friends and kin.

The concern in information leaflets is to address the kinds of questions it is assumed women will have about cervical screening. In doing so, the intention is to persuade women to identify themselves as women who have much to gain from participating in regular screening. Other kinds of literature, such as technical, research and professional literatures, have similar concerns embedded within them. For instance, *Professional Nurse*, *Health Visitor*, *Practice Nurse* and the *British Medical Journal*, periodically carry articles which address cervical screening and the difficulties associated with encouraging women to participate. These difficulties are addressed through a variety of categories, which often draw attention to the 'role' of various factors in preventing or facilitating participation. The presumed association between sexual activity and cervical disease has been central to discussions of (non)participation.

¹⁶ *ibid.*

Information literature places emphasis the role of authorities, parents, health care professionals and teachers, to spread information about cervical cancer. *Professional Nurse* carries such a piece:

'Parents, teachers and youth workers all have a role in spreading information regarding the disadvantages of coitus at a young age as well as the disadvantage involved in multiple sexual relationships. Notice the word 'disadvantage' rather than 'danger' is used - the idea of danger and risk taking can be very attractive to the young.'¹⁷

I will return to the relationship between 'sex' and 'risk' later in this chapter, but it is worth noting here how they are discussed by appealing to an authoritarian discourse of prevention. Here notions of risk are explicitly associated with the sexual activity of a particular social group, 'young women', and particular attention is drawn to the association between cervical cancer and 'multiple sexual partners'. Associations are made here between chronological age and sexual agency in ways which locate the idea of 'risk' within the practice of a particular understanding of 'sex'. However, attention is also diverted from sexual agency in a way which redefines all 'sex' as 'risky', and draws attention to the tensions between the identification of particular groups thought to be at risk from cervical cancer, and attempts to address all women in ways which will encourage them to think about the nature of their own risk. For instance:

'To imply that cervical cancer is *only* linked with multiple sex partners is unhelpful and induces not only sexual guilt, but also the idea that any symptoms in women who have not had multiple partners are not and cannot be dangerous.'¹⁸

Sex and risk are also conjoined by appeal to a neo-liberal notion of personal choice which is articulated through the idea of responsibility. For example, Edwina Currie, a vocal advocate of cervical screening, implored women in the 1980s to participate in screening by drawing attention to the particular risks associated with sexual activity in general. In an interview with *Family Circle*, she said:

¹⁷ Black, P. 1989, 'Cervical cancer: a preventable problem' *The Professional Nurse* April, pp338-342

¹⁸ Black, 1989 *ibid.*, p342

'The old fashioned values are good sense in health terms. The way young girls get cervical cancer is by being far too sexually active...Don't screw around and don't smoke.'¹⁹

Women are invited here to take personal responsibility for their own sexual practice and exercise choice in a particular direction, yet risk is used here both as a particular and universal category, in ways which are similar to general practitioners' use of 'risk'. For instance, research reported in the *British Medical Journal* demonstrates similar tensions between the particular and universal nature of risk associated with sexual activity.²⁰ In a discussion of the profile of the patients participating in one study, the language used by the author draws attention to these tensions. First, some women were not offered cervical smears 'because the woman was a virgin' or the practitioners 'considered it inappropriate'. This raises questions about the criteria practitioners use to make such decisions and the assumptions which guide their assessments of whether it is or is not appropriate, or whether women are 'virgins'. Second, some women did not have smears because it was 'not known if at risk'. The author reports:

'This latter category covered women aged 20-29 who were not known to be sexually active; unlike in older women we did not consider it appropriate to pursue such women to attend for a smear test without knowing their degree of risk.'²¹

This use of risk carries implications of redefining all sexual practice as 'risky' and in doing so, ensures that those defined as being 'at risk' carry the responsibility for reducing their own risk by participating in screening. Consequently, this use of risk both erases male partners as participants in the categories of sexual practice which are defined as being 'risky', and reinforces a neo-liberal version of prevention and citizenship.

In summary, the representation of cervical screening as a health check-up to which women are entitled, obscures the intervention necessary to

¹⁹ *Family Circle* April, 1988, p24

²⁰ Ross, S.K. 1989 'Cervical Cytology Screening and Government Policy' *British Medical Journal* 299: 101-104

²¹ Ross, 1989 *ibid.*, p101

treat abnormalities and potential disease. There is an implied connection here between cervical screening participation and the production and maintenance of health. This connection, is however, couched both in a discourse of individual responsibilities and social entitlements, and draws attention to the relationship between women's health and the state, through which such 'rights' are delivered. Furthermore, the representation of screening in both public information documents and research reports is often couched in moral terms (see for instance, Lupton, 1993, for further discussion of risk as moral discourse). Therefore, far from being a simple, straightforward procedure, locked into cervical screening are a range of articulations of citizenship. I turn now to the ways in which social science research agenda have approached cervical screening and the assumptions which inform these approaches.

Policy Issues and the Research Agenda: 1960 - 1990

The Organisation of Cervical Screening

Recurrent themes in the technical, policy and social science literature, include a consensus around the ways in which success has been measured; issues of organisation and delivery; the role of personal choice in addressing cervical screening participation; and, more recently, the way in which issues of risk are increasingly mobilised to secure and sustain female participation in cervical screening. First, published literature between 1960-1990 emphasises a strong statistical association between participation in cervical screening and mortality decline.²² It has been argued that this association is particularly marked for areas of Scotland, British Columbia and the Nordic countries, and has been linked to good population coverage.²³ Furthermore, research has highlighted that a high proportion of women with cervical cancer have never had a smear

²² For instance, Boyes, D.A., Fidler, H.K. and Lock, D.R. 1961 'Significance of in situ carcinoma of the uterine cervix' *British Medical Journal* i:203-205; MacGregor, J.E. et al 1985 'Case control study of cervical cancer screening in North East Scotland' *British Medical Journal* 290: 1543-6

²³ Hakama, M. 1982 'Trends in the incidence of cervical cancer in the Nordic countries' in K. Magnus (ed) *Trends in Cancer: Causes and practical implications* Washington: Hemisphere Publishing Corporation

test,²⁴ and that women who are screened have a low incidence of cervical cancer.²⁵

These data have been used to emphasise the need for systematic cervical screening, and to address the uptake of screening by women, which is consistently perceived as inadequate. However, less often cited in literature reviews is research which has drawn attention to stasis in mortality decline, despite the introduction of screening and research which more critically addresses the success of screening, or the way in which success is measured.²⁶ The success of cervical screening is measured in terms of mortality reduction in the long-term. In the short term, success is measured in terms of the disappearance of abnormal cells, or the disappearance of signs (Posner, 1991). However, the process through which abnormalities are eliminated may produce symptoms where none previously existed, such as bleeding, discharge and pain (Posner and Vessey, 1988). This tends to be obscured in representation of cervical screening and is under-discussed in the technical literature.

The second concern addressed in the technical and policy literature throughout the 1970s and 1980s, was the organisation and delivery of cervical screening. Of particular concern has been the location of responsibility for smear taking; the management of the cytological services; and concerns over women's non-participation. Both the British Medical Association and the Royal College of Obstetricians and Gynaecologists published their own appraisals of population screening,²⁷

²⁴ Paterson, M.E.L., Peel, K.R., Joslin, C.A.F. 1982 'Cervical smear histories of 500 women with invasive cervical cancer in Yorkshire' *British Medical Journal* 289: 896-898

²⁵ Chamberlain, J. 1984 'Failures of the cervical cytology screening programme' *British Medical Journal* 289: 853-854

²⁶ Foltz, A.M. and Kelsey, J.L. 1978 'The Annual Pap Smear Test: a Dubious Policy Success' *Millbank Quarterly* 56: 426-462; Brown, J. 1990 *An Annotated Bibliography of the Economic Literature Concerning the Evaluation of the Screening for Cervical Cancer* Health Economics Group Research Paper No. 9, Brunel University

²⁷ British Medical Association 1986 *Cervical Cancer in Great Britain* London: British Medical Association; Scientific Services Advisory Group 1987 *Report of the Ad Hoc Group of the Histopathology Sub-Committee on the Cervical Cytology Service in Scotland (The Strong Report)* Edinburgh: HMSO; Royal College of General Practitioners, Royal College of Obstetricians and Gynaecologists, Royal College of Pathologists, Faculty of

in which screening for cervical cancer was identified as opportunistic, locally organised and narrowly targetted at particular groups in the female population.

In the mid 1980s, both the BMA and the RCOG argued that many women were excluded from screening coverage and called for the government to increase funding for cervical screening. This call was intensified, when in the middle of 1986, the *Forrest Report*, commissioned by Kenneth Clarke for the Department of Health, prompted debate over a breast screening initiative. Edwina Currie, amongst others, made the point that if the government accepted the report's recommendations it would be difficult to refute calls for a co-ordinated cervical screening programme. Furthermore, both funding for AIDS research and breast screening was announced in January 1987. This focused debate on the absence of computerised call/recall systems, particularly in the north, where mortality rates were perceived to be rising.²⁸ In particular, cervical screening was perceived as failing to find those people most 'at risk' of developing cervical cancer,²⁹ namely young and working class women.

Public groups also expanded in the 1980s in response to the perception of the rising incidence of cervical cancer and the under-commitment of the government to fund a co-ordinated screening programme. Lobby groups such as *Women Against Cervical Cancer* and the *Women's National Cervical Cancer Campaign* denounced cervical screening as underfunded, understaffed, and non-computerised. A report by the *National Federation of Women's Institutes* in November 1987 surveyed 9,500 women, many of whom identified the perceived failings of the system.³⁰ Two thirds claimed they had never been offered a smear test; 25% didn't want to 'bother their GP'; another 25% were 'too embarrassed' and 20% 'feared the result'. The RCOG responded to this as 'disturbing' and used it to illustrate the need for greater prevention.

Community Medicine 1987 *Report of the Intercollegiate Working Party on Cervical Cytology Screening* London: Progress Press Ltd.

²⁸ *Guardian* 6 February, 1986, p4

²⁹ *Guardian*, 29 July, 1986 p2

³⁰ Reported by John Illman in *Daily Mail* 15 January, 1987, p15

Professional bodies such as the Public Health Laboratory Service and Area Health Authorities were consulted by the government about computerised call/recall systems for screening, although at managerial rather than professional level. This process of consultation also engendered a cost-effectiveness study to examine staffing levels in laboratories and the potential for replacing highly trained technicians with a semi-skilled workforce. This prompted what was seen by the medical establishment as backdoor manoeuvring by the government to expand screening without additional public cost. Re-organisation in the late 1980s therefore focused on institutionalising the responsibility for taking smears, and the management of cytological services. District Health Authorities in England were encouraged by the then Department of Health and Social Security in 1988 to implement computerised call/recall schemes in order to encourage general practitioners to invite women to attend for cervical screening and enable the screening of all eligible women by 1992.³¹

Similarly, the *Strong Report* (1987) in Scotland requested Health Boards to establish computerised call/recall systems to ensure that women aged 20-60 years would be invited for a smear test by the end of 1993 and recalled on a five yearly basis.³² In 1988, a Community Health Index was also established, which enables patients to be identified with a unique number which is computer compatible. The intention was to link this to a Cervical Screening Module which would identify women eligible for screening and allow more accurate monitoring of screening uptake rates.³³ However, there was little confidence that Health Authorities would be able to introduce computerised call/recall systems in the specified timescale. There are parallels to be drawn here between HIV and debates around anti-body testing. Local and Area Health Authorities were expected to implement HIV testing with no new funding and also establish

³¹ DHSS Health Circular 1988, HC(88)1/HC (FP) (88)2; Elkind, A. Haran, D., Eardley, A., Spencer, B. 1988 'Reasons for non-attendance for computer-managed cervical screening: pilot interviews' *Social Science and Medicine* 27(6): 651-660

³² See also SHHD/DGM1987(74) and SHHD/DGM(1987)78 Cervical Cytology Services in Scotland as indicated in the Scottish Office 1993 *Report of the Inquiry into Cervical Cytolopathology at Inverclyde Royal Hospital, Greenock* Edinburgh: HMSO.

³³ McKay, K. and Wallace, A.M. 1991 *A Report of a Survey of Cervical Screening in General Practice* Edinburgh: Department of Public Health Medicine

counselling in response to the uncertainty and anxiety which it was presumed such testing would generate. Similarly, Health Boards and Authorities were now being asked to establish a co-ordinated network of call/recall systems for cervical screening with no new monies. The failure of Health Authorities to meet the government imposed deadline of March 1988 to implement call/recall systems was therefore seen by professionals as inevitable and drawn upon to argue for further screening re-organisation.³⁴

Other revisions targetted Family Practitioner Committees to encourage general practitioners to take responsibility for the implementation of routine screening. This set the context for the introduction of *Promoting Better Health* (DHSS, 1987) and *General Practice in the National Health Service: the 1990 Contract* (DoH, 1989b) in which specific targets for screening were established. Cervical screening is now, therefore, pegged to general practice remuneration; quotas and targets provide incentives to general practitioners to offer smear tests, hence the context in which cervical screening occurs is increasingly defined by a market ethos. Furthermore, these changes have shifted the ways in which women might exercise choice in terms of where to obtain a smear and from whom. One Scottish survey of cervical screening carried out in 1991, indicated that seventy five per cent of all smears taken in one Health Board were taken by general practitioners.³⁵ Thus there has been a general shift throughout the 1980s, towards encouraging local and district health authorities, and health boards in Scotland, to provide and operate the structures within which general practitioners are encouraged to offer cervical smears to women.³⁶

The implementation of computerised call/recall systems has not vastly improved the uptake of screening and has been criticised for failing to

³⁴ Scientists and practitioners identified shortages of computer hardware/software; staff training and resources as problematic. *Guardian*, 8 December, 1987, p6

³⁵ McKay and Wallace, 1991 op.cit.

³⁶ These proposals and changes have largely been structured through shifts in general practice remuneration and have not been without their tensions. As Webster (1988) points out, issues of remuneration have always been central to the services offered by general practitioners and to the basis on which medicine in the community is practised.

reach, or for under-representing, women who are 'at risk' of developing cervical cancer,³⁷ such as women in low socio-economic groups and older women.³⁸ In part, this has been associated with the quality of computer software itself, the workload managed by laboratories and the general resources available to support call/recall systems;³⁹ and administrative problems such as the inaccuracy of the mailing lists on which such systems are based and knowledge concerning the whereabouts of the target population.⁴⁰ Current social science approaches to cervical screening continue to highlight the need for further re-organisation to reduce opportunistic screening,⁴¹ better follow-up and ways of ensuring participation;⁴² and ways of ensuring that 'attenders' do not become 'defaulters'.⁴³

Participation and Compliance

The third concern for technical and policy literature has been rates of participation and, in particular, non-participation. This concern has largely focused on the relationship between screening uptake and women's knowledge, beliefs and attitudes towards screening. There is a broad bifurcation in this literature between rational choice models of health behaviour and liberal feminist approaches to health care. In both approaches, there is a tendency to assume, that given specified forms of information, women will make informed choices and comply with the information with which they are presented. The adequacy of the expert

37 McKie, L. 1993 'Women's views of the cervical smear test: implications for nursing practice - women who have not had a smear test' *Journal of Advanced Nursing* 18:972-979

38 Nichols, S. 1987 'Women's Preferences for Sex of Doctor: a postal survey' *Journal of the Royal College of General Practitioners* 37: 540-543; Eardley, A. et al 1985 'Attendance for cervical screening - whose problem?' *Social Science and Medicine* 20(9): 955-962

39 Elkind, A., Eardley, A., Thompson, R., Smith, A. 1990 'How district authorities organise cervical screening' *British Medical Journal* volume 301: 915-917

40 Doyle, Y. 1991 'A survey of the cervical screening service in a London district, including reasons for non-attendance, ethnic responses and views on the quality of service' *Social Science and Medicine* 32(8):953-957

41 Nicoll, P., Narayan, K.V., Paterson, J.G. 1991 'Cervical Cancer Screening: Women's Knowledge, Attitudes and Preferences' *Health Bulletin* 49/3: 184-190

42 Nathoo, V. 1988 'Investigation of non-responders at a cervical cancer screening clinic in Manchester' *British Medical Journal* 296: 1041-2

43 Doyle, 1991 op.cit.

knowledge embedded within cervical screening is taken-for-granted, whilst the extent to which it is shared is criticised. Nevertheless, assumptions of compliance, are at times framed, in expert and media discourse, by reference to the domestic and family obligations which women are perceived to have, which disease is seen to disrupt. For instance, in the mid 1980s, Dr. John Davidson, head of BMA Scientific Division was quoted in the *Guardian* as saying:

'This disease has a major impact on families and children. We are talking about premature death. We have the technology to deal with it now.'⁴⁴

Within such statements lies an assumption that women *ought* to be concerned with prevention, not only in order to secure their own health, but in order to maintain their obligations to others. Compliance is the preferred outcome within much of this literature, although it is articulated through appeal to both personal choice and authoritarian models of participation. For instance, research in the early 1980s, in particular, focused on women's attributes, pointing to their 'failure' to take advantage of screening services.⁴⁵ Factors such as fear, perceptions of pain and embarrassment, are identified in this approach as disincentives to participation and screening uptake. Here women are seen as choosing to *not* participate in screening.

In contrast, liberal feminist approaches to screening identify women's inability to exercise choice to participate due to material barriers and organisation problems, of the kind outlined above. Similarly however, these approaches to screening also unproblematically link the provision of information to the exercise of choice.⁴⁶ Here women are identified as consumers of health care, but such models have as their goal, the production of data which can be mobilised to encourage and persuade women to participate in screening. Critical to both these models is the way

⁴⁴ *Guardian* October 8, 1986, p2

⁴⁵ Anon. 1980 'High risk groups and cervical cancer' *British Medical Journal* 281: 629; Chamberlain, J. 1989 'Failure of cervical cytology screening programme' *British Medical Journal* 289: 853

⁴⁶ Schwartz, M, Savage, W., George, J., Emohare, L. 1989 'Women's Knowledge and Experience of Cervical Screening: a failure of health education and medical organisation' *Community Medicine* 11:279-289; McKie, 1993 op.cit.; Doyle, 1991 op.cit.

in which compliance is normalised. This research takes as its starting point the notion that the beliefs and attitudes which women may hold, operate as disincentives and barriers to screening uptake. A key focus, therefore, has been to identify the nature of such knowledge, in which we can identify recurrent themes.

The first theme in this research is the crucial role which information dissemination, health education and publicity is seen to play in providing information about cervical screening.⁴⁷ Sources of information which women consistently identify include friends, kin, the media, campaign leaflets and health professionals. Health professionals, in particular, are identified by the social science literature as sources of encouragement to promote women's uptake of screening.⁴⁸ This literature identifies women's 'limited knowledge' of cervical screening and 'fear' as disincentives to cervical screening participation. Such literature poses women as disempowered through the language which is used to describe abnormal smears and the screening process. This literature is therefore concerned to redress the disjunction between 'limited' or inadequate knowledge and non-participation, by providing information for women as a source of empowerment. Furthermore, it assumes that expert knowledge sharing would establish conditions of compliance, although from my discussion of interpretive debates in Chapter Three, the adequacy of such knowledge to secure compliance must surely be questioned.

Second, a common understanding of the smear test amongst women is that it is a measure to detect, rather than to prevent, cancer.⁴⁹ This is often interpreted in the technical, policy and social science literature as 'poor' or 'bad' knowledge,⁵⁰ which prevents women from participating in screening. Other research identifies this kind of knowledge as 'invalid',⁵¹

⁴⁷ Wilkinson, S., Jones, J.M., McBride, J. 1990 'Anxiety caused by abnormal result of a cervical smear test: a controlled trial' *British Medical Journal* 300: 440

⁴⁸ Schwartz et al, 1989 op.cit; Savage, W. and McPherson, A. 1983 'Cervical Cytology' in A. McPherson and A. Anderson (eds) *Women's Problems in General Practice* Oxford: Oxford University Press

⁴⁹ McKie, 1993 op. cit.; Schwartz et al 1989 op.cit; Wilkinson et al, 1990 op.cit

⁵⁰ Nichol et al 1991 op.cit

⁵¹ Doyle 1991 op. cit. p955

or inadequate, and draws attention to further examples of 'invalid' knowledge which operate as disincentives to screening participation. Such knowledge includes not knowing about the need for regular screening; drawing upon a perceived 'invasion of privacy' as a deterrent; associating cervical cancer with 'promiscuity' in ways which prevent participation; and identifying embarrassment or pain as a barrier to participation. These knowledges are identified by liberal feminist approaches to screening as problems to be overcome in order to secure screening participation.

Indeed, many of the statements which women make in response to questions about their reasons for attendance, non-attendance and beliefs about the purpose of screening, are interpreted as knowledge deficiencies. Furthermore, women may be perceived as 'apathetic' about screening and urged to be more active in their response to screening. This is mirrored in journalistic discourse in which women have been identified as 'apathetic', or 'patient apathy' has been deemed the 'worst' enemy in relation to cervical screening participation. The response to perceived apathy is 'action'. For instance, in the late 1980s, Ann Robinson urged women to step up their participation and 'demand' smears from their general practitioners, citing Scandinavia as a model of progress and success and identifying the inherent risks of smoking; sexual activity and social class.⁵² A key assumption within such a position is that knowledge informs practice and that deficient knowledge can be changed in order to alter practice. It is assumed that the epidemiological connection between screening and mortality decline operates as an incentive to rational action on the level of the individual. Furthermore, this assumption underpins an implicit view that the woman who participates in screening will possess knowledge of a particular, pre-defined kind.⁵³

Hence, to understand the cervical smear test as prevention, rather than diagnosis or detection, is to hold good knowledge about screening. More recently, there is an acknowledgement that the language in which screening is framed is problematic, for instance, that 'precancer' is a

⁵² *Guardian*, August, 1988, p23

⁵³ Eardley et al, 1985, op. cit., p958

difficult concept for both women,⁵⁴ and for practitioners,⁵⁵ to understand. Research has identified the need to provide women with information which allays fears about what abnormal cells mean in order to prevent what one study terms 'future psychiatric and psychological morbidity and *improve compliance with treatment*'.⁵⁶ An entrenched response to acknowledged difficulties in perception and understanding is the provision of more information.

Therefore, in these approaches to cervical screening, women are identified in limited ways, as 'attenders', non-attenders' or defaulters'. Whilst the boundaries between these categories may vary between studies, they generally refer to women who have regular smear tests; women who have never had a smear test; and women who have had smear tests but have failed to do so regularly. This identification is important and the positioning of women in this way serves to mark out normality and deviance. Participation in screening is in the interests of social cohesion: non-participation is not in these interests. Hence research of this nature is oriented towards identifying ways of eliciting responses from women which can be used in the process of recategorising 'non-attenders' and 'defaulters' as 'attenders'. The difficulties of securing mass population participation are emphasised over ambiguities in the processing and interpretation of cervical smears. Furthermore, the provision of information feeds into feminist concerns with empowering women to resist subjects positions of passivity.

Posner's (1988; 1991) work is illustrative of this approach. On the one hand, she draws attention to problems inherent in the organisation and delivery of screening, the ambiguous language used to explain differences between normal and abnormal smears and the anxiety generated by the process of screening. On the other hand, however, her solution to the problem of screening is the provision of more information through which women might be empowered to challenge biomedical models of health care. Generally, liberal feminist approaches to cervical screening

⁵⁴ Wilkinson et al 1990 op.cit.

⁵⁵ Hopwood, J. no date *Background to Cervical Cytology Reports* West Sussex: Schering Health Care

⁵⁶ Wilkinson et al, 1990, op.cit., p440, my emphasis

place emphasis on the power of words to empower women to make decisions about their health and treatment. However, placing emphasis on language and information as a source of empowerment also comes close to identifying women as responsible for their own health and having a duty to participate in screening (Singleton, 1995). Hence empowerment in the liberal feminist approach to cervical screening has potential to slip, in ways which reinforce the importance of social duty and compliance. Indeed, empowerment in this framework is only identified if expressed *through* participation, and in liberal feminist discourse is equivalent in meaning to compliance.

Risk, Trust and Credibility

A third concern in literature which addresses women's knowledge is the way in which risk is defined and redefined. As previously discussed, risk is defined on one level in terms of socioeconomic position,⁵⁷ smoking,⁵⁸ chronological age and sexual activity.⁵⁹ As my earlier discussion suggests, this definition of risk is reproduced in information leaflets which are presented to women, in terms of identifiable activities which can be avoided, modified or transformed. On another level, epidemiological data are interpreted and used to mark out groups of women for whom there is a statistical connection between screening and the development of cancer.⁶⁰ In discussions of these connections, risk is redefined in terms of its relationship to screening, not in relationship to other forms of activity or factors. For example, research reports have begun to identify *not being* screened as a form of risk.⁶¹

Linked to risk categorisation are issues of quality control within the cytological services and problems of sensitivity in the detection of

⁵⁷ For a review of the epidemiological literature see Johnstone, K. 1989 *Screening for Cervical Cancer: a review of the literature* Discussion Paper 4/89: Health Economics Unit, University of Aberdeen

⁵⁸ Wigle, D. T., Mao, Y. and Grace, M. 1980 'Smoking and cancer of the uterine cervix: hypothesis' *American Journal of Epidemiology* 111:125

⁵⁹ Vecchia, C. et al 1986 'Sexual factors, venereal disease and the risk of CIN' *Cancer* 58: 935-941

⁶⁰ Ellman, R. and Chamberlain, J. 1984 'Improving the effectiveness of cervical screening' *Journal of the Royal College of General Practitioners* 34: 537-542

⁶¹ Nichol et al 1991 op. cit.; McKie, 1993 op.cit.

cervical abnormalities. A number of incidents in Birmingham, Liverpool, London, Greenock and Cambridge, have drawn attention away from issues of responsibility for the organisation of screening towards the interpretation of smear slides. In 1987, an 'error of judgement' became national news and exploded latent debates about the training of laboratory technicians; the knowledge base of pathologists and the exercise of clinical judgement within pathology. In Liverpool, a locum female consultant pathologist was accused of misdiagnosing 911 smear tests between 1983-1985. Laboratory staff questioned the judgement of the consultant, which was supported by another consultant colleague. A new consultant appointment followed up the query, reviewed the cases, and supported the laboratory staff in their allegation. Most of the women identified (487) were recalled for rescreening and in some cases treatment, and they set up a self-help group.

This case was interpreted by the broadsheet press as an error of judgement which could have been avoided if cytological services had priority funding, thus avoiding the employment of locum consultants who were most often near retirement age and female.⁶² The tabloid press also focused on the individual characteristics of the locum consultant involved, such as the age and status of the consultant (she was retired but was working as a locum) and her 'momentary inability to understand things'.⁶³

This case of perceived misinterpretation drew attention to the risks of the cervical screening system in the 1980s. What occurred in Liverpool, followed by a similar case in Oxford, was identified as the 'tip of the iceberg' and the nature of medical knowledge acquisition was debated in the media. During 1986 there was considerable debate on the social organisation of screening, the issue of medical competence and expert fallibility around smear interpretation.⁶⁴ A particular focus for attention

⁶² Other reports on perceived misinterpretation also identify these issues as errors of personal judgement, most recently the Scottish Office 1993 *Report of the Inquiry into Cervical Cytopathology at Inverclyde Royal Hospital, Greenock*, Edinburgh: HMSO, 1993.

⁶³ Reported in *Daily Mail* 6 November 1986

⁶⁴ In a study published in 1991, in the *European Journal of Obstetrics and Gynaecology* the authors reviewed literature on sampling quality of cervical smears by world region. The adequacy of smears in Holland, the

was the perceived need to balance clinical judgement on the one hand with a system which entailed cross-checking and peer regulation.

Medical competence in relation to smear taking was also targetted by the press and has been subject to professional scrutiny.⁶⁵ Poor skills were identified amongst general practitioners and in some cases, it was advocated that nurses be trained to take smears both on grounds of higher levels of competence and to reduce embarrassment amongst women. However, nurses had their own anxieties about smear-taking, for example, the *Royal College of Nurses and Midwives* acknowledged that nurses:

'fear they are inadequately trained to carry out some duties in doctor's surgeries'.⁶⁶

Singleton and Michael (1993) document the ways in which general practitioners themselves acknowledge opportunities for error in current smear taking practice, which potentially contribute to false negative rates. Incorrect sampling of the cervix, poor preparation of the smear slide itself, the microscopic screening and interpretation of slides,⁶⁷ can all mean that a test is returned to the general practitioner as 'inadequate', requiring a repeat smear test. Hence there are uncertainties attached to the process of obtaining a smear sample, which undermine the seamless and linear way in which screening is often represented to women. These uncertainties structure clinical management in two ways. First, practitioners respond to the smear test as an objective measure of cellular change and in doing so, respond to ambiguous abnormalities as something determinate. As Posner (1991) argues, practitioners draw on decision-

USA, Scandinavia and Britain were reported as 90%, 79%, 60% and 38% respectively (F. Buntin et al (42):227-230). Other studies draw attention to intraobserver variation, for instance, S. Ismail et al 1989 'Observer variation in histopathological definition and grading of cervical intraepithelial neo-plasm' *British Medical Journal* (298):707-710

⁶⁵ A. Singer and A. Szarewski (1988) challenge current smear-taking techniques and argue that the cytobrush is a better means of collection than the spatula because of the way in which it picks up cervical cells from high in the cervical canal. In the late 1980s this technique was not available to general practitioners or to Family Planning Clinics. Furthermore, the authors point to cervicography as a more progressive means of staining cervical cells which also involves *in situ* photography.

⁶⁶ *Daily Mail* 6 November 1986, p5

⁶⁷ For technical discussion of this problem see The Scottish Office 1993 op. cit.

making rules which guide them towards intervention rather than abstention. Second, the assumption of objectivity embedded within the cervical smear test enables medical culture to extend its control over uncertainty and ambiguity (Gifford, 1986).

Many of these issues have been recurring over a period of fifteen years, and demand analysis of the social organisation of the interpretive processes (Cicourel, 1968), through which smear classifications have been developed over time and are indeed currently made. Of particular significance is the relationship between gender, the production of knowledge and occupational divisions of labour. In review of these cases, one individual, typically a female, locum cytopathologist, near retirement age, has usually been criticised by technicians for poor decision-making and has subsequently been apportioned personal blame. This raises issues about the role of tacit knowledge and the way in which local judgements are made in laboratory contexts (Shapin, 1994). As can be seen from my discussion in Chapter Three, debates around classification and smear reliability also reflected divisions of labour between acute and community specialisms as well as the context in which these interacted. In the same way, a pattern emerges in contemporary debates around judgements made in the pathology laboratory.

Drawing on Shapin's work (1994) on truth and trust, what is significant in these cases, is how screening guidelines and local procedural rules shape clinical judgement and link decision-making to the context of laboratory observations. Scientific knowledge, such as that embedded within pathology and cytology, is created in conditions of familiarity (see also Luhmann, 1988), where face-to-face relations continue to be critical to the credibility claims of knowledge. The implication here is that local knowledges develop in ways which normally ensure consistency of smear interpretation. Trust is mobilised because pathologists are dependent on the observations of technicians, who make most of the observations in relation to cervical smears. Technicians diagnose 'negative' findings but not 'positive' findings, and there is little peer observation between pathologists, who therefore retain an 'authorial voice' in their identification of abnormal smears. The division of labour between pathologists, as 'experts' rewarded with responsibility, status and

autonomy and technicians as skilled workers who nevertheless carry out repetitious, eye-straining work (Clarke and Caspar, 1991b),⁶⁸ is sustained whilst conditions of familiarity and trust are stable.

However, these conditions of familiarity and trust may be disrupted when non-local pathologists are asked to make judgements about smears. Locum pathologists embody non-local knowledge which interacts with and disrupts local knowledge and definitional boundaries (see MacKenzie and Spinardi, 1995, for analogous discussion in relation to the nuclear weapons industry). Hence what may represent different definitional boundaries to those who embody non-local knowledge are interpreted by those who embody local knowledge as 'errors'. The paradox here is that technical staff, a hidden, feminised occupational category (Witz, 1992), perceive themselves, and are perceived by others, to be better placed to identify abnormal results, because their experience of examining all smears is greater.

Responses to these incidents have focused on counselling and reassurance in the short term, for women who experience 'false' negatives. At the same time, health professionals are usually concerned to restore public confidence in cervical screening, and to ensure that women maintain regular screening participation. The media has been instrumental in supporting this position. For instance, media reports on false negatives at the Inverclyde Royal Hospital, Greenock, emphasised that women should continue screening participating *despite* also drawing attention to interpretive and judgement errors in the processing of smears. Whilst problems were identified which undermine the knowledge claims of cervical screening, media accounts tended to adopt a normative position on the obligation of women to continue their participation. Hence, a manifestation of the rhetorical power of cervical screening is the way in which social obligation is discursively mobilised in public responses to

⁶⁸ Clarke and Caspar (1991b) argue that the feminisation of screening has been part of a strategy to redefine the *Pap smear* as an acceptable screening tool. Whilst I have not examined data which would allow me to agree with this point, the gendering of screening implicit in this argument raises issues for a Foucauldian consideration of screening. Developing this insight, we can begin to see how central gender is to health surveillance, in the way that, in this case, women are incorporated into the surveillance of other women.

what are perceived as administrative and interpretive errors. Indeed, the adherence to a normative position can also be seen as an expression of risk consciousness, as actors struggle to establish certainty in the context of uncertainty.

A second response, has been one of quality control. Discussions throughout the 1980s and early 1990s have focused on the necessity of eliminating 'false' negative reports and sampling errors through the introduction of external quality assurance to complement in-house quality control. Reports on what are perceived as interpretive and administration errors, such as those in 1993 for the Inverclyde Royal Hospital, Greenock, have also examined false negative rates; the general approach to cervical screening; and the staffing and operation of cervical cytopathology. Invariably, such reports also recommend clearly defined policies to be placed under the supervision of the consultant cytopathologist; laboratory computerisation and review of staff training. However, improving quality control in the cytological services raises its own technical problems, since good organisation may contribute to an increase in new smear abnormalities.⁶⁹ Consequently, many more women may be referred for colposcopy which in turn, raises questions about the impact of further investigation and treatment on women and fertility.⁷⁰

Sex and Risk

A final concern across the technical and policy literature is the general absence of attention to the role of men in the development of cervical cancer. The technical research literature has been equivocal about the aetiology of cervical disease. As I briefly discussed in Chapter Three, epidemiological research in the 1950s observed the absence of abnormalities within social groups which were assumed to have had little

⁶⁹ Raffle, A.E., Alden, B., MacKenzie, E.F.D 1995 'Detection rates for abnormal cervical smears: what are we screening for?' *British Medical Journal* 345: 1469-1452

⁷⁰ There is little research on the impact of screening and treatment for abnormal smears although it is clearly a source of professional concern for those working in this area. During fieldwork, for instance, nurses raised their concerns about the unknown long term impact of screening. Those with experience of midwifery had impressions that certain kinds of colposcopic treatment, such as diathermy, narrowed the cervix in ways which increased difficulties for women in labour.

or no sexual contact.⁷¹ This influenced further research which identified lower incidence rates amongst women within the Jewish community;⁷² higher rates amongst married women and women with children. These particular risk categories have evolved to include relationships with men at an 'early' age; relationships with more than one man; and sexual relationships considered to be 'too frequent'.

Research has drawn attention to statistical associations between the presence of cervical disease in certain categories of women, such as those with sexually transmitted diseases, including the transmission of human papilloma virus (HPV). Attention has also been drawn to potential carcinogenic properties in seminal fluid.⁷³ Associations between cervical disease and (hetero)sexual activity have become a marker which identifies risks for all women engaging in heterosexual sex and specific risks for some women engaging in particular kinds of sexual activity. Statistics pointing to rising incidence in the late 1970s and 1980s, were interpreted in the context of a perception of increasing heterosexual activity amongst younger women and also of increasing public awareness of HIV and AIDS. Furthermore, evidence pointing to epidemiological shifts in the age distribution of cervical cancer was interpreted by some researchers in moral terms, pointing to, for instance, the excesses of 'sexual liberation'.⁷⁴ An initial moral panic engendered by the observation that cervical cancer incidence was expected to rise amongst young women was also amplified by the media. Newsprint coverage of cervical screening from the mid to late 1980s in general is suggestive of an emergent moral panic, highlighting the 'virulence' of penetrative heterosexual sex amongst

⁷¹ Gagnon, F. was credited in the 1950s with conducting a 25 year study of 222 Canadian nuns in whom he found no cervical cancer

⁷² Priden, H. and Lilienfield, A.M. 1971 'Carcinoma of the cervix in Jewish women in Israel 1960-7' *Israel. J. Med. Sci* 7:1765 (cited in Robinson, 1982 'Cancer of the Cervix: occupational risk of husbands and wives and possible preventive strategies in pre-clinical neo-plasia of the cervix' in J. A. Jordan, F. Sharp and A. Singer (eds) *Proceedings of the Ninth Study Group of the Royal College of Obstetricians and Gynaecologists*

⁷³ Singer, A., Reid, B and Coppleson, M. 1976 'A hypothesis: the role of the high risk male in the etiology of cervical carcinoma' *American Journal of Obstetrics and Gynaecology* 126:110 (cited in Robinson 1982, *ibid.*)

⁷⁴ Husain, O.A.N. 1987 *Women's Cancer: positive action* London: Royal Society of Medicine/Women's Nationwide Cancer Control Campaign

young women.⁷⁵ The *British Medical Association* responded to this information with demands for priority screening for sexually active women.

Calls for a 'major drive' in screening were further underpinned through the identification of a link between cervical cancer and the wart (HPV) virus.⁷⁶ The authors of this study suggested that male sexual partners may introduce an infective agent to women during sexual intercourse or that the cervix reacts to certain compounds in semen. These observations were coupled with associations between cervical cancer and long-term use of the contraceptive Pill. Cervical disease has also been associated with women in lower socio-economic groups, where explanations about:

'...poor personal and sexual hygiene, poor medical care, loose living habits and unstable marriages, have been put forward...'⁷⁷

Other researchers dispute any link between social class and cervical disease,⁷⁸ but acknowledge the role of smoking and the contraceptive Pill,⁷⁹ or rather, the link made between Pill use, sexually transmitted disease and changes in sexual behaviour.

Robinson (1982) notes however, that associations between cervical cancer, multiple sexual partners and coitus at an early age, have been used to apportion 'blame' to women for developing cervical cancer, rather than to support the expansion of screening male sexual partners. The notion of *promiscuity* plays a significant role here in identifying categories of women in terms of risk. Examples of blame can be found in the technical literature, where the role of male sexual transmission is discussed.

⁷⁵ *Guardian* 22 October 1986, p7; *Daily Mail* 8 October, 1986, p12

⁷⁶ Chamberlain, G. 1981 'Aetiology of gynaecological cancer' *Journal of the Royal Society of Medicine* 74: 246

⁷⁷ Anderson, M.C. 1987 'Premalignant and malignant disease of the cervix' in H. Fox (ed) *Haines and Taylor Obstetrical and Gynaecological Pathology* Edinburgh: Churchill Livingstone 3rd. Edition p258

⁷⁸ Harris, R.W.C., Brinton, C.A., Cowdell, R.H., Skegg, D.C., Smith, P.G., Vessey, M., Doll, R. 1980 'Characteristics of women with dysplasia or carcinoma in situ of the cervix uteri' *British Journal of Cancer* 42: 359 (cited in Anderson, 1987, p258)

⁷⁹ Draper, G.J., Cook, G.A. 1983 'Changing patterns of cervical cancer rates' *British Medical Journal* 287:510-512

Anderson (1987) for instance, argues that some men may be carriers whilst others may not, therefore:

'the woman who is promiscuous is more likely to encounter a man who is a carrier, which may explain the high incidence of the disease seen in women who have multiple sexual partners.' (p259)

Whilst 'high risk males' may exist in biomedical discourse, this extract illustrates how they only become high risk in relation to 'promiscuous' women. Promiscuity is rarely, if ever, defined in the technical and policy literature, yet it is implied in clinical encounters. For instance, evaluation research highlights the implied promiscuity embedded within the experience of screening (see for instance, McKie, 1996), particularly where questions about sexual history and the number of sexual partners are elicited from a woman (Posner, 1991).⁸⁰ Those women who participate in screening, who have no children, and are in their twenties, are often asked to give an account of their sexual status and history, such as their age at first intercourse and the number of sexual partners they have had. These categories of women may also be asked about contraception and encouraged to take the contraceptive Pill. This advice is surprising given the emphasis placed upon the statistical relationship between the Pill and the incidence of cervical disease, but is unsurprising in that it reflects medical assumptions about youth, morality and femininity. Hawkes (1995) for instance, draws attention to the way in which general practitioners encourage young women to take the contraceptive Pill because their concern is to minimise pregnancy rather than to minimise disease. In contrast, sexual status and history is seldom routinely elicited from women with children or post-menopausal women.

Little of the technical, policy and social science literature in the 1980s has pointed to the role of men or male sexual activity in the development of cervical cancer. However, this has been a recurrent, although it has to be said, muted, theme in some of the feminist literature. Robinson (1982) has

⁸⁰ During clinic fieldwork I observed that where women had come for their first colposcopy, medical, reproductive and contraceptive histories were taken and some women asked questions about their sexual status and history. I return to this observation in my discussion of risk and sexual health in Chapter Six.

commented on the way in which the emphasis placed on screening participation has diverted attention from primary prevention. Drawing on *OPCS* mortality and morbidity statistics, Robinson's work has drawn attention to the way in which 'risks' have been obscured for women textile workers; women in relationships with men in dusty occupations; and women on the contraceptive Pill. In particular, the focus on screening participation as a form of prevention has drawn attention away from heterosexual activity and its relation to the production of cervical disease. In doing so, men have not been targetted as subjects for screening. More recent feminist research has begun to explicitly place the aetiology and experience of cervical cancer in the context of heterosexual relations (McKie, 1996). HIV-positive status has also been acknowledged as a marker of cervical disease (Bury, 1994) and feminists have also drawn attention to the previously unacknowledged incidence of cervical disease amongst women who identify themselves as lesbians (Richardson, 1994). These new commentaries are important, not least because of the way in which they potentially open up the issue of cervical disease and screening and point to issues of access to welfare and social citizenship.

Conclusion

In contrast to, and as a critique of, policy approaches to cervical screening, I have examined prevention as a site of power relations, in at least three ways. First, I have argued that embedded within the prevention paradox, illustrated in my discussion of the representation of screening and current policy concerns, are a range of notions of citizenship. Whilst cervical screening is represented as a simple form of secondary prevention, it is complex, and interwoven between notions of neo-liberalism and authoritarianism. Second, the issue of compliance is critical to understandings of current policy and technical concerns. Compliance is most often implicit in discussions of screening: it is simply assumed that women ought to participate in screening. Therefore much of the literature draws upon authoritarian models of participation. In contrast, personal choice and empowerment is mobilised by liberal feminist approaches to screening.

However, as my discussion demonstrates, compliance is also an implied outcome in this work, produced through the internalisation of adequate

information. The adequacy of information and knowledge is therefore the third issue for understandings of prevention, such as cervical screening. Recurring interpretive debates around smear reliability, the social organisation of screening and the embodiment of local knowledges in particular persons raises issues about the relationship between the form of knowledge held by experts and that provided for public consumption. Paradoxically, if women were provided with 'more information' about screening, rather than secure compliance, it would deter participation. Nevertheless, examining women's knowledge and attitudes to screening continues to be the principal approach within the social sciences to cervical screening.

In sum, uncertainty and risk can be provisionally understood as a *product* of the screening experience. This understanding should draw our attention to the tension between the uncertain benefits of prevention and the difficulties of identifying, with any certainty, those who might benefit from preventive strategies (see Klein, 1989, for instance, for a more general discussion of prevention policy). Smear misinterpretations, combined with the emphasis placed upon the need for regular screening, draws attention to the intensified observation over a period of time to which women are increasingly subject. Risk is mobilised in relation to cervical screening, as a set of categories, such as 'sexual activity', which are used to identify certain groups of women for preventive intervention. Risk, as a product of screening, is seen in the way 'false' negative rates, or increases in the background prevalence of abnormalities, reveal how the category of 'errors' are resolved in practice. This resolution raises questions about the nature of interpretive indexicality and the procedural rules which govern the classification and processing of smears. Practitioners themselves are becoming concerned with these issues expressed through, for instance, an increase in background prevalence.⁸¹ Whilst the thesis does not directly address these issues, they are implicitly addressed through much of the material presented in Section Three.

In what follows in Section Three, I consider the relationship between women's embodied interaction with the experience of screening, and the body as a cultural resource. Embodiment is central to the structure and

⁸¹ Raffle et al 1995, op. cit.

process of the thesis, which I use to express a dialectic between the body, as a universal category, and embodied experience, as a particular category.⁸² I am concerned here to examine how 'the body' is experienced and interpreted in the context of a preventive strategy, such as cervical screening. In turn, I examine cervical screening as an aspect of surveillance and draw attention to aspects of screening which have previously been obscured. In Section Three, therefore, issues of obligation and entitlement, risk and trust, will be addressed in relation to the knowledges and practices of cervical screening, in order to further examine the relationship between the body, gender and health.

⁸² Shilling (1993) uses the concept of embodiment to revisit Marx's observation that individuals make their own lives but not in circumstances of their own choosing. This differs, I think, from Merleau-Ponty's (1962) use of the notion of embodiment to express a dialectic between mind and body in which the latter retains biological stability. In contrast, drawing upon Gadow (1992), I use embodiment to express a dynamic between the body and embodied experience, on the premise that neither are fixed or stable.

SECTION THREE

In Section Two I introduced material which illustrates the relationship between prevention and surveillance in the context of cervical screening. In Chapter Three, I described local knowledges which have contributed to and developed from preventive discourse. Furthermore, I demonstrated how risk, as a category and marker of social groups, can be seen as a product of the negotiated character of surveillance. In Chapter Four, I described the interconnections between prevention discourse in cervical screening and issues of governance, and highlighted the complex ways in which governance is interpreted and represented.

In Section Three, I continue to unpack these interconnections through a discussion of interview material with women who have participated in cervical screening. In Section One, I argued that one of the ways in which sociology has addressed the body has been through the concept of surveillance, which, following Foucault, has engendered new identities. In Section Three, I examine this argument by exploring the negotiated experience of cervical screening participation and the expression of shifts in the nature of knowledge and the client-professional relationship. The experiences articulated here are diverse, but relate broadly to themes of obligation and entitlement, risk and trust, and reveal the sense of embodiment central to these articulations.

In Chapter Five, I describe how women place themselves as active participants in screening initiatives through the expression of obligation. This can be seen as a way of claiming attachment to screening despite quite contradictory experiences. Furthermore, many women experienced surveillance as a form of care provided by the state, and their negotiation of this experience articulates a sense of entitlement. For some women, making claims on screening as a form of social entitlement could provide an active mechanism for the management of ambiguity. I argue that the themes of obligation and entitlement are played out in ways which highlight issues of citizenship.

In Chapter Six I introduce themes of trust and risk. I draw on the interview data to demonstrate the ways in which the experience of

cervical screening participation and knowledge of an abnormal smear, for some women, transformed the relationship between lay and expert knowledge. Embodiment provided a medium of transformation in ways which displaced, undercut and heightened the degree of confidence which women felt they had in expert knowledge. In Chapter Six I argue that this reconfiguration of confidence relates to the production of risk in two main ways. First, the experience of abnormality for some of the women developed a sense of embodiment which was defined by internal limitations and articulated in terms of *risk as a state of being*. For other women, embodiment was redefined in terms of *being at risk*, not from cervical disease alone, but from the ambiguities and uncertainties associated with the 'abstract system' of which cervical screening is part.

In these two chapters, I present interview data in two forms. First, I present data as block text when illustrating a broad theme. Transcription units for this form of text refers to the original interview transcripts and are identified as [TU 1 - 5]. Second, when introducing a narrative to illustrate a process of reflexivity and negotiation, I present the data as text in numbered lines [01-05] and also indicate the transcription units from which they are drawn. This convention allows me to refer to specific phrases and ways of telling in my discussion of the data. Biographical details of the women who participated in the study can be found in Appendix I.

I reserve any methodological discussion for Chapter Seven. Chapter Seven presents an account of the thesis as a constructed negotiation and here I discuss the production of the thesis as an expression of my own local knowledge. My focus on the contested nature of abnormal smears emerged in the process of engaging with the concerns of the technical and policy literature on screening, as well as my interpretation of historical debates around smear classification and interpretation. Therefore, in Chapter Seven, I discuss the relationship between this process and the products of my research. For instance, in discussing the interview data, I attempt to make visible both the creative processes through which women in the study made their experiences meaningful to me and the way in which I have treated those experiences as meaningful. In Chapter Seven, I first discuss the process of negotiating access to a

regional colposcopy clinic, in order to identify women who might be willing to participate in the research. Second, I outline the process through which the interview data was analysed and third, I focus on the analytical role of narrative and its relationship to embodiment.

CHAPTER FIVE
OBLIGATION AND ENTITLEMENT
Social Duty, Empowerment and Responsibility

Introduction

As Section Two suggests, current understandings of cervical screening emphasise its role in the prevention of disease. The idea of prevention has been criticised as a form of medicalisation (Crawford, 1980), and, as Illich (1986) has observed, the pursuit of health is increasingly perceived as a social norm, as a kind of work to be done with and upon the body. Crawford, and others drawing on his work (see Lupton, 1994), identify health as a symbolic category which reveals tacit assumptions about social life, or where:

'bodily states are key markers in which are invested the social definitions of the self...' (1984, p60).

Following Douglas (1970), Crawford (1979; 1980; 1984) describes the body as a cultural object through which health operates as a moral discourse, as *healthism*. As the expression of a new form of consciousness, to which both prevention and the body are central, healthism seeks autonomy from medical terms, meanings and perceptions. Improving and protecting the body has been identified as part of a logic of health consciousness which developed in the 1980s, as part of a new ethic (Ehrenreich, 1983), played out through a regimen of restraint and denial (Glassner, 1995). Health and body maintenance has become a disciplined activity which requires the allocation of time in highly structured lives, and is most vociferously advocated by the middle classes (Bourdieu, 1984). Such ideas are also culturally pervasive as they are circulated and disseminated by the media (Lupton, 1994). For instance, injunctions to participate in exercise, the patronage of anti-smoking, the prevalence of vitamin consumption and the proliferation of health magazines highlight the predominance of health as a cultural category.

The notion of self-improvement within the middle classes draws on an idea of the body as a biophysical entity which can be threatened by physical agents and controlled by science (Crawford, 1980, p72). This idea of the body draws from the dominant assumptions of contemporary biomedicine,

in which the body is an object of rational control (Kirmayer, 1988). Therefore, within healthism, the normal becomes abnormal and subject to rational control and everyday aspects of life are increasingly managed (Arney and Bergen, 1984) often in collaboration with expert forms of knowledge (Armstrong, 1984). This view of the body is strongly associated with ideas about personal and social responsibility, which Crawford defines as a political discourse stemming from the self-help ethos emerging in the 1970s, and which I discussed briefly in Chapter Two in relation to women's health. Similarly, Herzlich and Pierret (1987) point out how self-groups of the 1960s and 1970s were based on identification of the limits of medicine, and challenged orthodox biomedical understandings of the body.

Self-help groups, many of which were feminist in origin, appropriated medical knowledge as a way of 'learning the language of professionals' and contributing to personal autonomy and empowerment, as I have argued in Chapter Two. Self-help groups were, and many would argue continue to be (Giddens, 1992), collective enterprises which break down the isolation of individuals in their management of disease and disorder. The basis of their relationship is voluntary and the nature of their task is reflective, stemming also in part from the inward-looking or narcissistic culture of the 1970s (Lasch, 1980). Self-help groups provided a means of collective identity mobilised around self-care, in an attempt to reduce the reliance of individuals on medical knowledge. Self-care included the development of diagnostic and therapeutic skills, as well as the adoption of disease prevention strategies. Empowerment through self-care, furthermore, has been linked to the development of a consumption logic within welfare states, where individuals are increasingly identified as 'partners' in the production of health (Armstrong, 1984).

Within the emergence of healthism, ideas about empowerment and responsibility have become intertwined. For Crawford (1980) responsibility, or personal autonomy, has become a symbol of empowerment, but is one which elevates the status of the individual, and obscures the power relations underlying the production of disease. Alongside the growth of personal choice, through which individuals may make decisions about the kinds of practices which will contribute to their

health, there increasingly coexists a social duty to pursue health (Herzlich and Pierret, 1987). Hence personal choice, autonomy and empowerment can also be seen as a new form of governance (Rose, 1990). As Greco (1993) points out, the notion of personal autonomy and choice, in neo-liberal discourse, can be seen to express internalised morality and rational will, therefore enabling boundaries to be drawn around those who express rational will and those who fail to do so. The expression of health as a personal choice, therefore expresses social membership. Prevention has become a dominant means of addressing health, and hence those who fail to express health, or prevention, as a personal choice, are subject to 'victim-blaming' (Crawford, 1979), or as we have seen in Chapter Four in relation to cervical screening, identified as 'defaulters'.

The pursuit of health, however, has also increasingly come to be seen as a form of social entitlement in welfare states. Whilst many areas of welfare are the focus of increasing contention, commitment to the notion of socialised health care remains high. Expectations around what the National Health Service can and should provide have risen and many people consider the provision of health as a key aspect of citizenship. Yet, with few exceptions, the hidden discourse within much discussion of prevention and personal responsibility in relation to health, is that of social democratic citizenship.

Preventive discourse, seen in this light, is a productive power which draws both upon a neo-liberal notion of autonomy and choice, and notions of both social duty and we shall see, entitlement, to mobilise individuals into both the construction and resolution of health issues. The idea of the body as an entity which can be known in a particular way, and which can be controlled through instrumental action, underpins the power of prevention. Concomitantly, the achievement of health is possible through instrumental actions and 'healthy' behaviours, which are aimed at enhancing the biological functioning of the body. In this view, the body is distinct from both mind and society, and comes to be 'managed' according to criteria elaborated in biomedical discourse (Crawford, 1984). Such management occurs through the internalisation of medical knowledge which is reproduced in everyday life and discourse, and contributes to self-policing activities.

This management, is however, also disrupted and (re)negotiated and it is this which I explore in this chapter. In particular, I place emphasis on embodiment, and how this mediates the social and cultural meanings of cervical disease. The cervix is often perceived as a taboo aspect of female embodiment. It is associated with reproduction as a gatekeeper of life and death and with sexuality as a site of pain and pleasure (Thomas, 1992). The cervix is seen by some in terms of contamination and pollution (Posner and Vessey, 1988) and not to be touched by self, only by sanctioned others. This kind of thinking may be expressed through some women's reluctance to wear tampons during menstruation (Laws, 1990). It may help to explain why cervical self-examination is perceived more negatively than breast self-examination since it involves a degree of familiarity with internal body space.

For the women who participated in this study, the cervix, as a discrete body part, was seldom an object of individual scrutiny prior to screening participation. For some women, the experience of cervical screening involved pain, discomfort and bleeding and they were made acutely conscious of their cervix both within this frame, and through the process of reflection which I asked of them in the interview context. Hence the experience of cervical screening was both fractured and contested, and the sense of embodiment articulated in the accounts which follow supports the notion of the body as a site of transformation and negotiation, particularly in relation to perceived boundaries between wellness and sickness. Women articulated their experiences according to similar broad themes but different themes also coexisted in single accounts. A common theme running through the experiences of many of the women was the way in which obligation to participate in cervical screening was constructed, perceived and manifest. Cervical screening was seen as something in which women were obliged to participate, identified as:

an everyday thing [Carol TU 59-60]

something which *just had to be done* [Sheila TU 26-27].

something that women *get used to* [Julie TU 61-62]

something that women *should go and get done* [Rose TU 97-99].

In this chapter I address three expressions of obligation articulated in women's accounts of their patterns of entry into, and experiences of, cervical screening. Expressions of obligation were mediated through rituals identified in the clinic setting; as an aspect of femininity; and finally through a sense of care owed to both self and others.

Rituals and Routines

A recurring feature of sociological literature on the experience of health in clinic settings, is the way in which the highly ritualised and ceremonial order of the clinic sustains power relationships (Strong, 1979; Roth, 1963) and marks social boundaries (Frankenberg, 1988). The rituals invoked by some women referred to those which regulate the female body within the context of the clinic, such as being asked to dress in ways which can accommodate medical examination, or by perceiving the clinic to be impersonal in ways which anticipate judgement about women. The control of time and information was perceived by some women as constraining and regulatory. For example, Alice (32) first had a smear eighteen months prior to our discussion in response to a 'Well Woman' invitation from her general practitioner. She indicated that she had had a 'bad time' and felt 'very uncomfortable' during this encounter, although she did not elaborate on this. She found out five weeks later, via a computerised letter, that her smear was abnormal and that she should see her own general practitioner 'as soon as possible'. Here she recalls discussion about this with her general practitioner:

Alice Extract 1: TU 55-56

- 01 I was told to put it out of my mind,
02 that I had an abnormal smear and had to have an examination
03 to see the extent of the spread,
04 but that I didn't have cancer, that it was precancerous...
[
05 AH: How did you feel about it?
[
06 Frightened and concerned...I had a weekend of waiting,
07 because I got the letter on a Friday...
08 it was a weekend of not understanding...
[
09 AH: What did you think it meant?
[
10 I thought it meant cancer of the cervix...
11 ...I thought about what spread meant,
12 of how it might affect my fertility
13 and I thought about death.

Alice's response here is to a 'routine' procedure which points to further investigation [01-02]. This produces anxiety for her [06-13] which is undermined by the instruction of her general practitioner to 'put it out of her head'. She was invited to attend for further examination at the colposcopy clinic and here she reflects on what she considers her inability to 'assert herself'. When she arrived at the hospital she recalled that she:

Alice Extract 2: TU 91-92

01 had to take off my clothes, put them in a basket and put on a gown,
02 and I was asked to participate in a study for new treatment.
03 But I had no information about this, like what the old treatment was.
04 I in fact had the old method, loop diathermy,
05 since it had spread too much rather than cold coagulation.
06 I wasn't surprised at having an examination, I was used to them,
07 and there was nothing I minded being asked...
08 my partner came with me, but not when I had the colposcopy,
09 although I would have liked him with me.

In this account, the perceived agenda of the clinic dominates and sets the framework for Alice's interpretation of her experience. She is asked to engage in the ritual of presenting herself for examination [01-02], with which she complies. However, she is aware of the way in which both ritual, time and the control of information regulate her experience [03-04]. Although her partner stayed with her until she had colposcopy, she implies that again, her experience is regulated by clinic routine [07-09].

On reflection, she thought she had not asserted herself, had not been able to question the events at the clinic because they were part of a routine order. She explained how she felt disempowered because of the tight time controls imposed on her, and how she felt obliged to comply with the instructions issued her at the clinic. She sums up her assessment of this obligation thus:

Alice Extract 3: TU 100-101

01 I hadn't asserted myself at the time I went to the clinic,
02 that bothered me...I was literally doing everything I was told,
03 but there was no time for explanation, no apologies...
04 I was disappointed that I had such little control over myself.
05 Because there was little time everything was rushed
06 and I felt I had an obligation to comply with the treatment,
07 but I was given no choice, and there was an unspoken pressure,
08 although I knew they were under pressure too...'

Here Alice's obligation to comply with treatment is structured both through the medical management of time, by being rushed [03-05] (see also Roth, 1963; Frankenberg, 1988) and the perceived assumption of compliance [05-07]. Importantly, however, Alice's account does not draw on disempowerment to explain her experience. Rather than focus only on the way in which power is taken away from her or exerted over her, Alice's account also points to the way in which her autonomy is undermined, which makes it difficult for her to sustain a sense of embodiment as a woman 'in control' of the situation in which she finds herself. Alice is given minimal explanation of the process of examination and treatment being offered [03], despite the fact that she is also being asked to participate in research which is nominally covered by codes of conduct and ethics and which require informed consent from potential subjects of that research [Extract 2 02-03]. Furthermore, Alice is aware of the expectation of obligation and refers to the 'unspoken pressure' on the part of the staff that women will comply with clinic procedures and treatments [05-07]. Her perception that she has little or no control is thus reinforced. She does not understand this in terms of being dispossessed of power, but of the contingent nature of power [03-04].

Indeed, she acknowledges the conflict between her identity as a professional woman used to taking responsibility for her actions and her clinic identity as a woman unable to assert her autonomy [08], expected to conform to the rituals and routine of the clinic. This sense of obligation was reinforced by the fact that:

'they want women to have smears and women want to have smears'
[Alice TU 142-143]

Rituals and routines in clinic settings are clearly an important way of creating and sustaining a sense of obligation to participate in examination and investigation. However, both a notion of the routine and of perceived obligation extended beyond the social space of the clinic. Many women saw screening as part of a more general set of routine procedures which they could expect across the life course. Ann (28), for instance, had little contact with health services prior to her abnormal smear. Her first smear, at the age of 20, was at the Family Planning Clinic and her memory was that she was 'due to get a smear' and 'there was a big sort of scare on

about...something to do with the Pill and cervical cancer' in which she remembered that 'there was a big rush 'of women wanting to have a smear and 'make sure they are alright and everything'. Whilst Ann did not use the term 'routine', her perception of being 'due to have one' conjures a notion of routine, or of a perception of a socially appropriate time in which to be initiated into screening. When I asked her if she had been conscious or aware of her cervix prior to her first smear, she said:

'I don't think about it. I don't really...I suppose I would have been about 20 or something when I went for my first smear and *I really thought it was par for the course*. I didn't really think about what it was all for.' [Ann TU 27-28 my emphasis].

Whilst the question refers directly to the cervix, Ann responds in relation to screening in general, in a way which suggests that her perception of screening was a part of a more generalised set of examinations as part of women's reproductive health. Ann's perception of screening as *par for the course* has a degree of inevitability attached to it. In addition, she assumed that screening was associated with cancer detection. The following extract illustrates this.

Ann Extract 1: TU 19-20

01 I suppose at the time I thought it was for cancer,
02 for checking out cancer which I suppose...
03 well it's not particularly cancer
04 but just changes they're looking for,
05 but at the time I thought [if] there's something abnormal
06 - you've got cancer.
07 It was all...it wasn't really...nowadays especially
08 with all this happening in Glasgow with the smear tests,
09 I mean, it's on the news all the time and everyone seems to know
10 what it's about now. But at the time
11 it wasn't very often talked about.
12 You didn't really understand it.
13 *You just knew you had to go and get a smear test and that was it*.
[my emphasis].

Here Ann is reflexive about the nature of her knowledge about cervical screening prior to and in the context of her participation [05-12]. This new knowledge is expressed by appeal to a preventive discourse [01-04]. However, she expresses her initial participation in terms of obligation which is linked to the perceived routine and inevitability of screening [13], as something which is part of the routine surveillance which women experience rather than the monitoring of health. Furthermore, Ann

places this memory in the context of a 'big scare', in which cervical disease and the contraceptive Pill are linked to her experience in ways to which she feels obliged to respond.

Liz (32) also had her first smear in the context of family planning, around the age of nineteen. Asked to describe this, she said:

Liz Extract 1 TU: 4-5: 22

- 01 I cannae mind exactly, but I'd say I was 19...at the doctor's...em...
02 probably with family planning. I mean,
03 *they had me down for family planning* so that would
04 suggest I had a smear test then....
[
05 AH:What did you think the smear test was for?
[
06 It's necessary to find out if you have something wrong with you...
07 *I just knew you had to have it...*[my emphasis]

Like Ann, Liz places screening in the context of the routine examinations which women might expect as part of their reproductive careers [01-04]. The doctors 'had her down for it' suggesting that she was not proactive but responded to an examination in the context of other routine procedures. She later invokes its necessity by saying she 'knew you had to have it' [07].

A stronger sense of obligation to participate in screening came from Pat (43) who described her first experience of screening in the context of pregnancy when she booked in for her first baby at the age of twenty three. She described her anxieties about the impact of the smear on her unborn baby and her ambivalence to smears. She characterised her participation in ante-natal care as reluctant and performed in ways which identified her to medical and nursing personnel as a 'non-complier' in general and a 'late-booker' in particular. The following extract illustrates this ambivalence and reluctance.

Pat Extract 1 TU: 44-48

- 01 I was 23, pregnant for the first time. It was taken by a doctor
02 in the ante-natal clinic...It was done as a routine [the first time].
[
03 AH:How did you learn about the smear test?
[
04 I was told at the time. I vaguely knew about it from time spent
05 working on a gynae ward.
[
06 AH:Were you keen to have one?

- 07 No. [
- 08 AH: How important do you think it is for women to have a smear? [
- 09 If smear testing reduces death from cervical cancer [
- 10 then it is important. If not, and I am not convinced
- 11 that it does reduce death rates in women,
- 12 I think it is an intrusion by medical people.

Again, the pattern of entry into screening in Pat's case is through what is perceived as a 'routine' procedure which occurs in the context of women's reproductive health and pregnancy [01-02]. Pat is not proactive in her participation but instead, responds because the smear test is placed in the context of pregnancy, as a routine measure. There were anxieties for her, connected to the technique of taking the smear. For instance, she was worried that the 'scraping' of the cervix would put her into premature labour. She felt her body was vulnerable, yet nevertheless, she felt obliged to participate in screening. Significantly, the ambivalence Pat expresses is mediated through the 'expert' knowledge represented by medical culture, as Pat herself had been a nurse [04-05]. However, her embodied experience transforms expert knowledge into local knowledge, in ways which underpin both her reluctance and her sense of obligation to participate.

Ivy (33) too articulates this sense of obligation. Her first ever smear was also at her booking appointment with her first child thirteen years prior to our discussion, and here she talks about her initial perceptions of screening.

Ivy Extract 1: TU 14-15

- 01 At that time, to be honest I thought they were checking you
- 02 for something like they check to see if there's anything there.
- 03 I knew it was related to cervical cancer but I didn't think
- 04 they suspected I had it or anything like that.
- 05 I understood it was like a blanket screening, kind of thing
- 06 - everybody was getting it so...I knew it was connected
- 07 to cervical cancer but I never went into any great detail about it,
- 08 it was just a blanket screen that everybody got and that was that..

Like Pat, Ivy's first smear was associated with pregnancy and she places it in the context of a 'blanket screen' which 'everybody' gets [05-08]. Therefore, screening for Ivy was something with which she would comply

not because of a prior knowledge about its efficacy and reliability, although she presents a knowledge of this [01-04], but because of its application to women *in general*. This perception of general applicability and universality contributes to Ivy's understanding of her participation as a compliant subject.

This pattern is also evident in Eve's account. Eve (44) was apologetic throughout our discussion for not 'providing interesting information or complaints'. Her previous contact with health services was mainly in connection with her pregnancies, one of which she explicitly booked in late for because she 'didn't like examinations since they were usually carried out by a man'. Although she could not remember her first ever smear she recalled that she had had an invitation from her general practitioner to go for a smear three years prior to our discussion.

Eve Extract 1: TU 8-27

- 01 I got a letter from the Well Woman clinic saying, you know,
02 that I was due for a smear test - I hadn't had one for a long time
03 and so I went to Dr. Smith over in [the] Health Centre...
04 it might be just over three years ago...and when it was sent away
05 they found that some of the cells weren't right so
06 I had to attend in Edinburgh since then.
[
07 AH: So the letter came out of the blue for you?
[
08 Yes...
[
09 AH: What was your reaction to that?
[
10 Well...just hoping that it wasn't cancer or anything like that,
11 that's the kind of upset that comes into your life.
[
12 AH: Right, what made you think it might be?
[
13 Well, it's quite a...quite a lot of women get that now you know.
[
14 AH: Had you had a smear test before?
[
15 It's been quite a long while. I hadn't really...
16 oh I think the last time must have been when I had Mandy and she's
15...
[
17 AH: Did you remember much about it?
[
18 Well it was Dr. Smith at the centre that done it. I suppose just...
19 it never really bothered me too much. I used to feel...
20 I suppose you could say butterflies...you know, kind of funny,
21 but then once you get up and get on with it it's OK like.

- 22 It was *just one of those things, I just know that*
 23 *you've got to get it done. You know, you find out everything's OK.*
 []
 24 AH: Did your doctor tell you what the smear test was for and
 25 what it involved at the clinic?
 []
 26 Not really, no. *You just get used to people telling you..*
 27 *they advise you to get it done like...just like a check up.*
 [my emphasis]

Eve first presents a summary of her story here [01-06] in which she briefly outlines how she has come to know that she has an abnormal smear. She follows this by describing both her initial response [10-11] and then her reasons for participating in screening [18-23]. Eve articulates resistance to participation in other areas of her reproductive experience. Nevertheless, she responded to an invitation to have a smear on the grounds that she 'ought to have it done' because 'you find out everything's OK', which in her experience was not the case. She was aware of its purpose and had some information about what it entailed, yet despite an initial reluctance to participate she does so on the grounds that it was expected of her.

A further example which illustrates a shift from initial resistance to compliance is the case of Fiona (34), who had her first ever smear at an ante-natal booking clinic. Here she talks about how she perceives the benefits of screening, by developing an account through which she renegotiates her initial reluctance and accepts the obligation which she sees as incumbent upon her. The extract which follows is slightly confusing because of the way in which Fiona moves back and forward in time in her telling of her account, using her 'new' knowledge to inform her interpretation of her pre-screening knowledge.

Fiona Extract 1: TU 45-46

- 01 Well, me personally, if I hadn't had a smear test I probably
 02 wouldnae be telling you this. I got this smear test, the second one...
 03 I think it was after the last one [child] and it was a year before I got
 04 another smear test but the smear was normal.
 05 So it really means I got this smear test, the second one...
 06 because I was pregnant I had to wait a while
 07 before they did another one.
 08 *I think it's really important that you get them...*
 08 although I must admit before that
 09 it hadn't really given me much thought.
 10 I got them when I was pregnant but that was the only time.

11 I wouldnae have actually asked the doctor but now I would ask,
 12 because I had an abnormal one.
 13 Before, I had done anything to avoid it.
 14 The very first time I was pregnant, I didn't want to have an internal
 15 the first time I was pregnant, so I went
 16 when the doctor was really really busy
 17 and the doctor asked, he says, how long ago have you had a smear?
 18 And I knew that maybe I'd had it a year ago and I said, I've no idea.
 19 So I didnae get a smear test then.
 20 He said, well we'll do it after the pregnancy.
 21 But I didn't even get an internal until I was actually in labour.
 22 But I realise now *I shouldn't have done that* ,
 23 *I should have went back and had another smear.*
 24 It's important that you do. For me anyway
 25 I had blood tests which came back abnormal so I had to get taken in.
 26 But I don't know if that was because during
 27 the same time I had the abnormal smears and I was actually waiting
 28 to go for treatment but I couldnae go because I was pregnant...
 29 I don't know if that affected the blood tests...[my emphasis].

Fiona presents a mortality tale [01-02] here in which she describes her experience of her first smear and the tactics she used to avoid having smears taken [05-06; 10-20]. She was initially reluctant to have smear tests because of their association with internal examinations which she earlier had indicated she found sore. She knew about smears as she elsewhere says:

'I just assumed they were taken for cancer...I knew they could come back abnormal.' [Fiona TU 67-68]

She did not, however, actively seek them out until they caught up with her in the context of pregnancy and childbirth. Indeed, the initial action she invokes is one of avoidance by adopting delaying tactics and identifying 'safe' moments to visit her general practitioner when she perceived that he would be too busy to take a smear [15-20]. Embedded in her narrative is the sense of obligation which has emerged from her experience [08; 22-23].

Reluctance to participate because she wishes to avoid internal examinations is replaced in Fiona's account of her experience by anxieties over the impact of having a smear on her baby. She was having blood tests which may or may not have been connected to the abnormal smear, and there was some uncertainty in her perception of the management of the smear test. Elsewhere she says:

'I hope they know what they are doing.' [Fiona TU 105]

Fiona's sense of reluctance is also reinforced by the response of her general practitioner to her avoidance strategies. On one occasion when she went 'late' for a smear, her general practitioner reprimanded her thus:

Fiona Extract 2: TU 60-66

- 01 I went late the last time and she [her GP] went absolutely crazy.
02 She said, make sure you have your smear...but for people
03 who haven't had smears I don't know what their doctors would say.
04 Maybe they would say, if they didn't want one
05 they would just leave it.
[
06 AH: How late did you go the last time?
[
06 I had an appointment at Elsie Inglis, it was every six months
07 and then they got yearly.
08 Well they forgot to give me a yearly appointment
09 so I contacted them and they said they would send another one out
10 but they sent it for another three months
11 and so I don't know whether..
12 maybe it was just the kids and everything. I forgot all about it...
[
13 AH: So your doctor wasn't very pleased?
[
14 No, so I had to phone up again and Elsie's werenae too pleased
15 and they said they would refer me.
16 It might be easier for you to go to your doctor.
17 So they wrote me a letter saying to me just to contact my doctor
18 and so it was a while before I eventually
19 got around to going to the doctor
20 and she said, oh, I was going to write to you. [pause]
21 It is a thought going though.

The professional response to Fiona's reluctance to go for a repeat smear [01-02], which may have been compounded by the material difficulties of finding time and space to go to either the hospital or her general practitioner [09-12], was to signal her failure to comply [14-16] and to confirm her identity as a reluctant participant. This did not improve the experience of screening for Fiona and she responded to requests and invitations at points when they connected with material openings for her in terms of time and space, reinforced by the embodied experience of pregnancy.

The reflexive nature of these accounts highlight how structures of time and routine reinforce a sense of social obligation to comply with examination and investigation. These women identified themselves, first, as resistant to, then subsequently, as compliant with a perceived obligation to participate in screening. The context in which these women were invited to have a smear test further contributed to this sense of obligation because of the way in which non-compliance is perceived to carry implications for reproductive outcomes and their sense of embodiment. In these accounts, the normative power of cervical screening is apparent.

What begins to emerge is a picture of a surveillance continuum along which women are placed, and into which women might be drawn at particular points. Obligation to participate in screening is reinforced through normalisation processes such as clinic rituals and appeal to the 'routine'. The generation of anxiety further contributes to this sense of obligation. On the first count, these women perceived screening as a normal aspect of reproductive health care and on the second, anxieties associated with reproductive outcomes reinforced their compliance. These processes of normalisation were grounded in the structures of time and routine which create boundaries around acceptable and unacceptable forms of participation in cervical screening. Nevertheless, whilst these women responded to the perceived imperative, they did so in their own terms by adopting tactics of hesitancy and reluctance.

Regulated Femininity and Responsible Citizenship

Cervical screening was also seen by some women as a routine procedure associated with femininity, with part of being/becoming a woman. For instance, Mary (39) associated her understanding of smear tests as part of a 'common knowledge' which certain women would have:

'...Women that have been...sort of...on the Pill, or had children, or things like that should go for smear tests.' [Mary TU 52-53]

Mary links cervical screening here to both sexual activity and reproduction. Susan (36) makes similar connections. Her previous contact with health services was minimal and she had participated in screening since the age of sixteen in the context of family planning.

Susan elaborated on the notion of 'common knowledge' and commented that she would make her daughter go for smear tests 'as soon as she is old enough'. When asked to explain what she meant by 'old enough', she said:

Susan Extract 1: TU 126-127; 214-215

- 01 I don't know...eh...to be perfectly honest with you.
- 02 I mean, they're no really fully developed are they, at even 12.
- 03 I don't know what age they start doing smears on them...
- 04 I think maybe...it depends how mature they are...
- 05 I would say maybe 15 or 16.
- 06 Because, I mean, it could be lying there,
- 07 and they would catch it in time
- 08 or whatever. I think maybe 15 or 16 they should have...
- 09 because obviously they're having their period at that age
- 10 and so surely they should be able to have a smear
- 11 by that time as well.
- 12 Just as I say with Lisa, I would definitely get her a smear test
- 13 and that when she's old enough to have it done, you know?
- 14 I would never let her say, 'I'm no going'.
- 15 If I had to drag her, I would drag her.

This normative view of femininity as regulated was further supported by statements referring to the initiation of young women into femininity. For Fiona, for instance, screening was also seen as something which should be part of the education of growing up as a girl, linked to learning about menstruation, sexuality and reproduction. Furthermore, she identified the nature of women's participation in terms of whether they were good or negligent citizens:

Fiona Extract 3: TU 80-81

- 01 I think everybody from the age of maybe...
- 02 oh, when you start having sex. I think that girls
- 03 should be more aware. Like at school when they get
- 04 talks about periods and things, I think they should
- 05 be taught about cancer smears as part of growing up.
- 06 I think I wasn't very good, if I'd thought about it, to me,
- 07 it was just a nuisance, getting a smear.
- 08 I thought it was uncomfortable
- 09 and an embarrassment. I think you should start it early,
- 10 but I think you should continue them on.
- 11 No woman wants to have them,
- 12 but I think you should have them more often.

The obligation to attend for a smear test and the examinations and treatment which an abnormality engendered clearly implied a compliance which could be linked to routine interventions which regulated female bodies. The smear test was also seen as a gender marker. Cervical

screening for these women, symbolised transitions to adult femininity represented by the onset of menstruation, initiation into sexual activity or pregnancy. This form of obligation could also be seen as a form of self-surveillance ('starting early, keeping regular, going often') and was considered important by women who did go regularly for smears, or who claimed that they would do so in the future.

Obligation could therefore be read as a cultural expression of normative femininity, in which the latter, as a public understanding of responsibility, is incorporated into the world of private conduct. Thus women who did not participate in screening were perceived by those who did so, as negligent citizens, and moreover, sometimes perceived as unliberated and out of tune with their bodies. For instance, as Linda (37) reflected on her first smear experience, she struggled to present a picture of herself in terms of responsibility. She tried to discount her feelings of discomfort as she talked about her experience. She did not, for instance, remember feeling embarrassed, but acknowledged that embarrassment might have manifest itself in ways which she would not, in retrospect, recognise. She says:

Linda Extract 1: TU 14-15

- 01 ...I didn't really feel too bad about it.
- 02 I thought this was very necessary,
- 03 this needs to get done and I gauged my reaction
- 04 in contrast to other women
- 05 I know women who actively avoid going for smears
- 06 and some who I suspect might have never gone for smears at all
- 07 because they just find it too embarrassing, and I just find that so...
- 08 I suppose I think that's nonsense.
- 09 I feel sad - that's a terrible way to feel.
- 10 It's a shame.

This extract is framed by a discourse of responsible citizenship, where Linda perceives participation in screening in terms of necessity [01-04]. She presents herself as an 'informed' woman and implies that women who participate in screening know that this is best for their bodies and health, and have been freed from constraints of femininity which make it difficult for women to subject their bodies to examination or discussion [08-10]. Indeed she expresses sadness and presents a normative femininity which is open to scrutiny, which does not get embarrassed under a medical gaze since this is a gaze which has 'seen it all before'. The

understanding of femininity which Linda presents here is one which is rational and calculative, a regulated, yet self-possessed femininity, through which she actively constrains expressions of irrationality, such as embarrassment.

Linda's account compares both with liberal feminist notions of empowerment where embarrassment is seen as something to be transcended, and with neo-liberal ideas about self-governance which demand the transcendence of the 'irrational'. Such work highlights the ways in which both women and health professionals perceive that 'having children' or being sexually active anaesthetises women against any embarrassment which might be experienced by an internal examination. As phenomenological research suggests, during examinations such as that associated with the taking of a cervical smear, the actors involved define the situation as a clinical rather than as a sexual encounter (Emerson, 1970; Henslin and Biggs, 1982). Posner and Vessey (1988) describe this struggle to place emphasis on the clinical nature of internal examinations and draw attention to the ways in which women in their study deny a place for embarrassment in their experience of cervical screening. The 'motherhood effect' here could also be seen as an expression of the way in which deference and compliance are expected and mobilised in the context of client-professional relationships. Hence the responsible citizen in cervical screening is one who identifies the screening experience in clinical terms and partitions the potential for embarrassment, by moving it from the potentially sexual to the reproductive sphere.

Within liberal feminist debates around health, sexuality is associated with 'privacy' and it is privacy which is seen to be disrupted in medical encounters, such as those incurred by cervical screening. This is mobilised when feminists encourage women to challenge questions about sexual activity which are asked by doctors and other health professionals, in order to protect liberal notions of privacy in relation to sexuality. However, when women attempt to protect their privacy and use embarrassment as a means of doing so, they are perceived by other women and feminist commentators as resisting participation. Embarrassment is discounted as a rational response to screening by liberal feminists who

seek to 'empower' women to take control over their health. Further, within this discourse of empowerment, refusals and other resistances are effectively discounted as rational responses to the screening imperative.¹ Empowerment, by, for example, overcoming embarrassment, is a norm which has come to mean participation and compliance within liberal feminist accounts of screening. Therefore, the various uses to which the notion of embarrassment are put reveal the instability of boundaries between notions of the public and the private as they are mobilised in prevention discourse.

Both the rationalisation of the female body and the logic of surveillance are reinforced where the importance of the individual in the production and reproduction of self-governance is emphasised. Other women mobilised notions of responsible citizenship and individual choice, but in ways which identified the importance of information in order to secure entitlement as a rational course of action. Liz, for instance, a member of a women's group which campaigned for more information about cervical screening and which supported women with abnormal smears, said:

'I think you should get more information, I think it's my right to get that information, but I know that for some people it can cause embarrassment. But you should be able to get it from your doctor or go to the library.' [Liz TU 36-37]

This notion of rights was further articulated by Lorna who perceived reluctance on the part of her general practitioner to give her a smear test. She said:

'I went for a smear and she said, she asked me if I was on the Pill or anything like that and I wasn'ty at the time. And so she said, you're not entitled to a smear. She said every five years, but...then I had the coil fitted so you're actually entitled to have it done every three years.' [Lorna TU 75-76]

Susan also expressed a notion of entitlement in which health care is linked to consumption.

¹ Drawing on Actor Network Theory, Singleton (1995) makes a similar point about the ways in which way some women may 'position' themselves outside screening by, for instance, highlighting material barriers to participation. She does not, however, use this insight to address issues of surveillance.

'If I went and asked for a smear and they wouldnae give me it then I would fight to get one. I just wouldnae say, oh well, that's it then. I'd say, well, look it's my womb and I want it done. It's my body, you're my GP. You're meant to do what I'm wanting done, you know. I would fight for it definitely.' [Susan TU 122-123]

Responsible citizenship was also articulated in other ways. For instance, one young woman suggested that having smears ought to be 'like giving blood', a distinctly public minded form of behaviour. Chris (21) perceived cervical screening as taboo and that it ought be 'detabooised' and become even more routine through, for instance, advertising.

Chris Extract 1: TU 334-342

01 I don't know if it's regular practice here to offer smears
02 when you reach a certain age.
03 Maybe it depends on what doctor you go to.
04 I don't know. But I think it's a good thing,
05 if you come to a certain age.
06 I suppose maybe you should lower the age now, because, definitely,
07 people are having sex younger now than they did do
08 and maybe they should lower that age to 17. Maybe even 16.
09 I suppose it's going to be a bit of an ordeal
10 for someone who's a bit younger - going for a smear -
11 but it should become a common thing, like
12 going to give blood...to have your smear, it's an important thing.
13 Probably I don't think it's talked about enough.
14 It's like a taboo subject.
15 So the more taboo it is,
16 the more apprehensive people are going to be doing it.

This extract places cervical screening participation in a more authoritarian or social democratic discourse of responsible citizenship in which cervical screening is seen as something which should become a social norm [09-12]. This stands in contrast to the neo-liberal versions of citizenship articulated above, with their emphasis on notions of personal choice. For Chris, as a young woman negotiating her sexual identity in the context of a recent sexual relationship, screening for cervical cancer was also part of a wider set of social taboos which she perceived as requiring redress [13-16]. She draws links between the personal and the public as a means of increasing participation and consequently locates notions of responsibility in the public domain. For Chris, bringing the private conduct associated with screening into public discussion, operates as a normalising strategy which places emphasis on social norms. Furthermore, this extract draws attention to the 'technologies of

citizenship' (Rose, 1990) such as advertising, which regulate the private sphere through the production and dissemination of social norms.

Obligation can also be seen as a response to the perceived potential for the detection and curability of cervical cancer. In some accounts, prevention and cure are indistinguishable. For instance:

'I just knew it was something you should go and get done basically, at that time it was every 5 years or so they advised it should be done...em...I knew why they did it obviously, to watch out for cervical cancer. [Rose TU 94-95]

'Oh I knew what it was for, I knew it was for cervical cancer. I knew what it was for.' [Margaret TU 185]

'I had to go since it it is curable' [Alice TU 35-36].

'Obviously just to prevent anything like cancer appearing. That would be it. It's certainly not a nice experience, you know?' [Ann TU 83-84]

The indistinguishability between prevention and cure, and the notion of disease progression as an inevitability sometimes co-existed in women's accounts. For instance, Rose, who moved back and forwards between normal and abnormal smears over many years, alludes to this when she says:

Rose Extract: TU 464-475

- 01 I suppose if I hadn't had the smear to begin with,
- 02 things could have been a lot worse. I wasn't...
- 03 I mean I didn't feel that there was anything wrong with me.
- 04 I didn't have any problems with my periods or anything like that,
- 05 so I don't know whether I would have done, if I hadn't had a smear
- 06 and just carried on with things.
- 07 I don't know if I would have felt whether there was eventually
- 08 something wrong with me or not.
- 09 But obviously the longer it goes on the worse it becomes,
- 10 at least being picked up at that stage...
- 11 it was for most people easy to cure,
- 12 for most people it would have been.
- 13 But certainly it's not a serious problem or anything, you know?

A disaster narrative is introduced here by reference to screening as cure [01-02]. For Rose, 'picking it up before it got worse' was an important aspect of the experience of screening, despite the ambiguity and perpetual

state of abnormality in which her own experience was cast. Cervical disease is perceived here as inevitable progression and screening as an objective test which will reveal hidden disease [03-08]. The sense of cure is strong when abnormalities have been recognised and treated, but this could also cross over into an articulation of prevention.

Yet even where preventive treatment has apparently failed (for instance, subsequent smears are abnormal) the obligation to participate is still strong. So for instance, Susan explained her position if she had another abnormal smear.

Susan Extract TU 104-105

- 01 Oh I think I'd be devastated. I'd just remember
- 02 everything that I went through this time.
- 03 I'd hate to have another abnormality, I would.
- 04 I think most other women feel the same though.
- 05 You expect when you get the treatment that it's over and done
- 06 and you're cured or whatever.
- 07 But then if I did have that, I wouldn't not go.
- 08 I would go but I'd know what I'd be like again - up to 90.
- 09 As long as I wasn't kept waiting I'd probably be OK.
- 10 I'd be thinking, 'oh no, no again please.' No that's OK.
- 11 I'd definitely go back. I wouldn't not go.

Eve also invokes this notion of revealing the unseen within the context of a medical or expert gaze in her explanation of participation.

'...the only thing is just as I say to make [sure] I go now and not miss...you know, go regularly...just to get it checked out...just in case....just in case there are any signs of cancer because that's something that bothers me.' [Eve TU 118-121]

Here the expression of compliance is expressed by reference to the sense of security provided by screening participation. Eve draws on an assumed certainty of expert knowledge which, rather than confirming the absence of cancer, *reveals* the possible presence of cancer.

The conflation of cervical cancer as both preventable and curable might be interpreted as an expression of 'knowledge gaps', such as those to which I referred in Chapter Four. However, this indistinguishability is linked to a sense of obligation to participate and indeed persuade other women that they ought to participate. Some of these women draw on a

sense of responsible citizenship to articulate their embodied experience of cervical screening. Despite considerable ambiguities, anxieties and ambivalences, many see themselves as moral agents who, by placing their bodies under surveillance, also meet social expectations, or exercise social duty through the expression of what they see as rational action. Furthermore, the expressions of self-governance here, through choice and entitlements, highlight an active and engaged sense of participation in cervical screening.

Negotiating Surveillance and Care

'I'm going for smears, I'm doing everything I can.'
[Diane, TU 85-86]

Finally, obligation was expressed by some women in relation to a perceived regimen of self-care and watchfulness over other women. For instance, an obligation to inform and persuade friends and kin of the necessity of screening features strongly in some accounts. Similarly, some women expressed a sense of increased vigilance in relation to their own screening participation. Mary recounted how she responded to a sister and a friend who were requested to attend for a cervical smear. The following narrative extract illustrates how Mary places emphasis on the way in which this vigilance is expressed.

Mary Extract 3: TU 48-49 'The Persuasion'

01 ...a couple of years ago she says to me
02 — they've sent me a thing for a smear.
03 I'm not going and opening my legs — she says.
04 And that's the sort of attitude she had,
05 and I said I think you'd better be going.
06 But I never made any comment that
07 I had problems or anything like that.
08 Some women, as I say, they say it's embarrassing.
09 I've a friend who actually came with me when I went for a smear
10 and the nurse was saying about what's up with these women
11 who just won't come for a smear?
12 And I says her out there won't come.
13 Well she got nabbed for an appointment and she had...
14 well she did go.
15 To me, they just don't bother.
16 I think it's a thing you should...

Mary first introduces her sister as non-compliant [01-03], and indeed appeals to 'privacy' to ground her non-compliance. Mary's own critical

voice is embedded within this story and she actively obscures her own struggle to deal with the ambiguities in her own experiences of screening [05-07]. She acknowledges the reluctance of other women to participate and the way in which women appeal to 'embarrassment', as a means of explaining their non-participation [08-11]. Despite her own struggles however, Mary presents her own participation in terms of obligation. Her reference to her sister [01-03], her friend [09] and the nurse's observation about women who do not participate [10-11], all draw boundaries around her own identity as a woman who has acknowledged her social obligations and those women who have failed to do so. The nurse's reference to 'these' women especially operates as an identity marker which alerts us to Mary's consideration of her own sense of embodiment.

In recalling her response to her sister, with whom Mary no longer has contact, she is clear that she considers the best course of action for her is to have a smear. Yet she immediately qualifies this definitive statement with reference to her own experience, which was characterised by a series of abnormal smears, examinations, normal smears and treatment. Yet she alerted neither her sister nor her friend to this complex experience and indeed submerged it in a positive statement of the necessity of screening. This indicates a certain ambivalence on the part of Mary. On the one hand she clearly states what she perceives as the correct course of action, yet on the other, she does not wish to reveal the extent to which her own abnormalities remain unresolved. Thus she prioritises the needs of the system over her own needs for answers, in order to persuade her sister of her obligation to attend to her health [05]. Her obligation to what she perceives as prevailing social norms outweighs her desire to find answers to her own dilemmas. There is, therefore, a mismatch expressed here between her own ambivalence and her response to a perception of social obligation.

In her reference to her friend, Mary is more beligerent. She reveals to the nurse taking her smear that her friend falls into that category of women who 'avoid' having smears. She is therefore exposed as a 'defaulter', deviant, an outsider. Mary felt justified in providing the nurse with this information and may have done so on the assumption that the nurse would then approach her friend and 'nab her for an appointment',

thus providing no means of escape or resistance [13]. Therefore, not only health professionals participate in the opportunistic screening of which many women complain. Indeed, some women themselves may participate in this watchfulness over other women through a sense of obligation to reveal to kin and friends ways of maintaining health and preventing disease, and in doing so, appeal to an authoritarian discourse of citizenship.

A sense of watchfulness was evoked by some women in relation to the care they received in their experience of screening, and the way in which nurses in particular tried to provide information from which women might make decisions. However, this sense of care could be counter-productive. For instance, Julie suggested the 'cosy, all women' atmosphere of health centres and colposcopy clinics undermined the clinical context in a way which was unhelpful for her, precisely because of the way she was expected to make decisions and, therefore, deal with their consequences. Kathleen echoed this sentiment. She was full of praise for the way in which she had been reassured and her anxieties had been addressed by both her general practitioner and the clinic. However, such reassurance could also be counter-productive. For instance, she said:

'...perhaps they collude with you in underestimating the impact of having somebody...having gone through this panic that you've got cancer, and just having that physical assault - and it is one - it's so...*minimised*. And there's this big notion that it's all preventive and that it's wonderful. And you think, yeah, that's great, but it actually minimises the bit that says this is frightening. It's traumatic and an assault on your body.' [Kathleen TU 48-49]

Obligation to participation in response to watchfulness is expressed here in ways which draw on neo-liberal notions of information and choice. X

A sense of watchfulness was expressed through the identification of the impact of the experience of others upon them, or the ways in which their experience impacted on other women. For instance, Margaret perceived screening as evidence of 'progress' because they were unavailable to women when she was younger. Margaret also acknowledged her response to her daughter's implicit watchfulness over her:

'My daughter always goes and my chum goes and one of my other friends - she had a mastectomy, she still goes for her smear tests - so I thought I'd better go' [Margaret TU 147-149]

'...we never really heard of them until the things that your family, your daughters and your daughters-in-law go through.' [Margaret TU 113-114]

Margaret's previous contact with health services were minimal and she indicated that she went to her local health centre if she had 'flu' or a 'bad cold'. She was prone to bronchitis and was initially reluctant to respond to an invitation to visit her general practitioner for a smear test.

Margaret Extract 1: TU 29-57

01 Um...they're all very nice around there and Dr. Paul,
02 I mean you can sit and talk to her as if I'm talking to you.
03 She's great, she's a great wee buddy. In fact whoever, she said
04 phone the surgery if I wanted to talk to her
05 so I went round and I did that,
06 I made an appointment to see her and she showed me
07 all the pictures of the cells you know at each different...
08 and normally it's - my age group, this is the time
09 when they like you to have a smear test,
10 because the body's changed
11 because you've been all through the menopause,
12 I mean I went through the menopause when I was about 43, 44,
13 and no bother, no problems I mean I never needed a doctor
14 or needed to be put on the hormone replacement
15 or anything like that
16 and that's what Dr. Paul said to me yesterday
17 'you've always been a very well woman'. I said 'aye'.
18 That's why I've always been against the cervical smear test,
19 because I've always been a very well woman.

Margaret identified herself as a *well woman* and therefore not in need of medical examinations and tests [19]. As she recounts her experience, however, there appears to be a shift in the status of screening and its relation to her sense of embodiment as a *well woman*, which moves from a location outside screening participation to one in which screening is an important aspect of her sense of embodiment as a *well woman*. Margaret's objection to screening, is articulated through her sense of embodiment. Screening therefore is not, initially, connected to being a *well woman*, as part of a programme or wider regime of healthy behaviour and strategies.

For Margaret, her perception of screening is also linked to a life course transition [08-12]. She evokes time in terms of the changing body in ways which link it to a sense of normality and sanction medical monitoring and intervention. She says of her age group, for instance:

'...this is the time when they like you to have a smear test, because the body's changed, because you've been all through the menopause...' [Margaret TU 36-38]

Margaret's account of her screening experience incorporates a more active definition of *well woman* which introduces new 'practices of self' through the persistence of her general practitioner. Margaret's doctor also mobilised the notion of *well woman* as a means of getting Margaret to agree to a smear test in the first instance [16-17]. The implication here is that the smear test will confirm this sense of embodiment.

Yet, *well woman* is evoked both by the general practitioner to support cervical screening and by Margaret, to reject it. The notion of the *well woman* operates as a 'helpful discourse' (Foucault, 1990, p101) which supports her shift from non-participation to participation. However, her sense of embodiment as a *well woman* is articulated through her experience of inhabiting a body which does not break down or require medical intervention. This sense of embodiment is confirmed by her doctor but is broken by her first contact with screening in which she has an abnormal smear. Indeed, it is the fragility of her embodiment which is threatened and renegotiated by the knowledge of an abnormal smear and which gets transformed in the process. Margaret's doctor emphasises the *preventive* aspects of screening in her response to the fears expressed by Margaret that it is disease which has been revealed.

Margaret Extract 2: TU 50-55

01 'Well' she says, 'it's OK, everything's fine,
02 prevention is better than cure'
03 and I said 'oh well that's right'. I think my daughter even said that.
04 She said 'mum, you're lucky,
05 if you hadn't had went you would have gone on',
06 I mean it did say on the letter in 10-15 years
07 it could have gone onto a serious cervical cancer, you know.

There is a conflict here between Margaret's sense, in Extract 1, of what a *well woman* is and the views of her doctor and her daughter. Her doctor

emphasises that screening prevents cervical cancer [01-02] and her daughter mobilises the idea that disease which was revealed was better than disease which remained unrevealed [04-07]. Both these views, emphasising the revelatory aspects of modern medicine, stand in contrast to Margaret's sense of embodiment as a *well woman*. This account also draws attention to the way in which ambiguous knowledge can have a disruptive effect on embodiment which individuals then have to negotiate and renegotiate.

Other women identified the impact of the experience of others on them. For instance, Fiona links her own experience of participating in screening with her sister's abnormal smear.

Fiona Extract 4: TU 91-92

01 I don't think my family were bothered either.
02 My sister had a smear test that was abnormal
03 and then the whole family went out, and all my friends went out
04 and got appointments to get smears taken,
05 even folk that wouldn't normally...every one of them,
06 they panicked, thinking cancer.
07 I think that's all it takes really, just a fright.
08 Somebody that you know anyway, and that's you alerted.
09 I do remember anyway my mum and my sisters going...

A sense of vulnerable embodiment is being drawn upon here as a source of connection with other women [02-07]. Fiona draws links between her sister's embodied experience and that of other women in her family to underpin her sense of obligation.

A link between obligation and the life course was evoked in other ways. Participation in cervical screening was seen by some women as part of the responsibility of maturity (acting your age, being rational) based on an assumption that the result will have 'normal' outcomes. Rose illustrates this perception:

Rose Extract 1: TU 478-484; 488-492

01 ...when she suggested to me that I make an appointment to go back
02 and have a smear done - they did it on particular afternoons...
03 I thought, 'I'm not going for that'.
04 I must admit, I went away and I thought,
05 'I'm not going for a smear'. But, however, later on I thought,
06 'that's stupid, act your age' and so on...
[
07 ...My conscience...I don't know if there was any inner knowledge

08 that I wasn't aware of, but I just thought,
09 'this is stupid, it's no big deal, go and get it done.
10 It's time you had one anyway'. So I went along.
11 But I mean, I didn't expect to have anything
12 other than a clear result, you know?

Screening participation here is expressed here in terms of age-related maturity and responsibility [10], in ways which impute moral agency to a particular point in the life course [09]. Some women's accounts draw attention to the trajectory of the life course and a sense of particular moments which have to be respected. Women over thirty five years old, in particular, appeared to acknowledge a point at which they saw themselves as responsible persons in relation to notions of maturity which were expressed in terms of 'acting your age'.

Some women resisted the initial obligation to participate by redefining the ways in which they did so. The embodiment of time could be used to negotiate entry into cervical screening and to control transitions between resistance and compliance. Many women reconstructed the ways in which they had 'put off' screening from their personal agenda through redefining and recategorising time. The point at which such negotiation was difficult to sustain was when there was some recognition of participation as a social norm. For instance, this was acknowledged by Rose:

Rose Extract 2: TU 114-124

01 ...it's one of those things that most people put off.
02 There's very few people who I know who actually voluntarily go
03 for these things, that make a point of going.
04 I think it is becoming more and more the norm,
05 certainly you hear more people talking about it...

Obligation is articulated in many of these accounts, as women came to identify themselves as compliant participants in cervical screening. Watchfulness over self and others was expressed here in ways which invoke a set of social relations which might be characterised as an ethic of care (Gilligan,1982; Young,1990).

Subjectivity, Obligation and Citizenship

[Care of the self] 'is the development of an art of existence that revolves around the question of the self, of its dependence and independence, of its universal form and of the connection it can and should establish with others, of the procedures by which it exerts its control over itself, *and of the way in which it can establish a complete supremacy over itself.*' (Foucault, 1988, p238-9, my emphasis)

Whilst the force of this statement in Foucault's later work, *The Care of Self* (1988), invokes a notion of power in which self is understood as empowered and autonomous, the material I have presented here describe a range of experiences of cervical screening which are, nonetheless, framed by a common culture of a sense of obligation to participate. Obligation is expressed and understood in at least three ways. As I argued in Section One, Foucault outlines a relationship between surveillance and self-surveillance, in which first, individuals internalise the values of dominant discourse (Foucault, in Gordon, 1980). In relation to cervical screening, this is a discourse of prevention. Second, as power/knowledge produces interests which intersect with those of individuals, in turn, individuals begin to act in ways which intersect with those of the dominant discourse. Hence power is a dynamic and productive force in the Foucauldian framework, which sociologists of the body have sought to harness to issues of health.

However, whilst this model points to the productive nature of power, the way in it has been developed in the literature leaves very little space in which to identify the 'multiple resistances' and implicit negotiated action to which Foucault refers. Prevention, as an expression of surveillance, whilst administered through the state, is not done so coercively to ensure widespread compliance, nevertheless, compliance is an implicit objective. Consequently, in this chapter I have presented material which describes the negotiated character of participation in forms of surveillance, such as cervical screening. Obligation should not be seen as an expression of coercion, although at times pressure from professionals or other women is evident. Rather, this was interpreted as part of the rituals and routines associated with reproductive femininity. Nor should obligation be read as an expression of disempowerment. In many cases, both obligation and critical engagement co-existed in ways which undermine liberal feminist

arguments which position women as disempowered by their experiences of cervical screening. Obligation should be seen as a more complex expression of self-governance, through which women express a sense of moral agency which emerges from an active engagement with the process of screening. Cervical screening participation provides a space in which women are active participants as moral agents in relation to both self and others (Hirst, 1981). Such action is supported by prevention as a 'helpful discourse' (Foucault, 1988), which read through gendered embodiment, can also be seen as an 'ethic of care' (Gilligan, 1982).

As feminist discussions of embodied experience and issues of health have indicated, and as I have outlined in both Chapters Two and Four, notions of entitlement, empowerment and choice are all evoked through discussions of autonomy, and in turn, are seen as central to posing challenges to medical culture. Women are encouraged to claim social entitlements in the domain of health, by for instance, requesting cervical smears from their general practitioners. Autonomy and empowerment in this literature, tends to refer to either overcoming embodiment in order to subject one's body to scrutiny, or implies drawing upon embodiment to challenge medical culture. The material presented in this chapter poses a third interpretation which is that the sense of embodiment, articulated by women who discuss their screening experience, is complex, and articulates a sense of obligation. Obligation to participate, as an expression of embodiment, is linked to three notions of citizenship.

First, some women appeal to neo-liberal notions of choice, autonomy and entitlement in their interpretation of their experience. Increasingly, individuals are implicitly and explicitly encouraged to engage in what Rose (1990) has termed 'liberal governance', as the language of choice and the market enters the organisation and delivery of health care. For instance, the boundaries between the public and the private have been reordered through the introduction of quotas and targets. Within this framework, citizenship is expressed through active self-maintenance and notions of choice and entitlement. The liberal, autonomous individual is encouraged, and indeed, is obliged, to take up social entitlements such as that represented by cervical screening. The autonomous individual, as a reflexive citizen, and indeed as a consumer, is obliged to be aware of her

embodied experience and 'become skilled at translating embodiment into medical discourse' (Greco, 1993, p361) in ways which express a sense of personal choice but, nonetheless, meet the demands of a medical agenda.

However, whilst a neo-liberal notion of choice is mobilised in women's accounts of their screening experiences, this is elsewhere modified by other expressions of responsible citizenship. The experience of cervical screening as a routine feature of regulated femininity, appeals to an authoritarian version of social obligation. This should not be read as merely the internalisation of normative authority, but rather, as an expression of both a social duty and the embrace of social entitlement, through which women place themselves as part of a moral community. Responsible citizenship, however, can also be understood as an ethic of care, which emerges through statements about the role women take, not only in relation to self-care, but also in relation to their watchfulness over other women. The concern displayed by some women for others who form part of their social network, draws attention to a notion of relational citizenship (Gilligan, 1982; Young, 1990). Here female embodiment can be seen as a site of transformation in which responsibility is both required and reinforced through the logic of surveillance.

The diversity of experiences of participation in cervical screening, highlights a tension in the construction of cervical screening as an issue of entitlement and autonomy. The accounts of women in this study support a view of screening as a form of regulation in which individuals are obliged to participate in specified ways. As responsible citizens, women are expected to 'choose' to participate in screening, and in the neo-liberal version of citizenship, to consume cervical screening, in order to maintain a sense of well-being and secure embodiment. Whilst governance is evoked by appeal to neo-liberal notions of individual choice, an increasing reliance on the language of the market has not completely foreclosed a space in which moral agency may be exercised (see Wolfe, 1989 for a critique). Such agency may be exercised in ways which are not immediately apparent, since it operates within a private domain which is revealed by tapping into female embodiment.

Whilst screening participation represents a form of social citizenship, it is also entered into through relations of surveillance over self and others, which, for some women, is characterised by a sense of moral agency. This form of surveillance is not one of coercion and control, but one which is embraced and entered into, through a process of negotiation. Whilst women expect to subject themselves to medical surveillance, as the data suggests, at the same time, they develop a critical response to their experience. Hence, obligation expresses local knowledges which are the consequence of negotiation and reflection.

CHAPTER SIX
SURVEILLANCE, RISK AND TRUST
Knowledge and the Limits of Embodiment

Introduction

'Technologies of domination and control compel silence; technologies of monitoring and surveillance incite discourse.' (Arney and Bergen, 1984, p170)

As I have implicitly suggested in Sections One and Two, issues of risk and trust have emerged as key themes in late modernity and are critical to understandings of cervical screening as a form of surveillance. Parsons (1951), for instance, identified trust as a mechanism which sustained medical power as it developed as a profession, and trust has been central more generally to the expansion of professional relationships in capitalism. Sociological discussion of professional-client relationships and their historical transformation with the development of citizenship, has drawn attention to the way in such relationships have historically been based on a high degree of trust. However, recent discussion has highlighted the changing nature of these relationships in the context of redefinitions of citizenship. It has been argued that trust has shifted from a context of personalised relationships, such as those characterised by deference, for instance doctor-patient relationships, to a context of abstract, expert systems (Giddens, 1990). Trust, in late modernity has been transformed into a pragmatic acceptance in which scepticism coexists with taken-for-granted confidence. As I argued in Chapter Two, feminist discussion of the interaction between medical interventions and female embodiment points to the ways in which expert knowledge can be a source of ambivalence for women. In turn, this raises issues about the boundaries between confidence, trust and risk.

Giddens (1990) makes a distinction between trust and trustworthiness in which the former is established when individuals are known to each other or when expertise is seen as reliable. This creates a sense of security in which we can subsequently place trust. In contrast, Luhmann (1988) makes a distinction between confidence and trust which emphasises the significance of a transition from familiarity to unfamiliarity. Conditions of familiarity, such as those in pre-modern times, are characterised by limits to knowledge which in turn, are sustained by confidence. In

contrast, conditions of unfamiliarity, such as those of late modernity, are characterised by the limitless expansion of knowledge, or by uncertainty (Beck, 1992). Therefore trust functions to establish a sense of the familiar from conditions of unfamiliarity, and I suggested in Chapter Four that these relations pertain to the creation of knowledge in relation to cervical screening.

Trust was also evoked, at a general level, in the stories which women retold of their screening experiences, as something which allowed and protected legitimate medical intervention. However, the accounts presented here highlight how screening participation fails to foster the 'day-to-day' security identified by Giddens (1990), or confidence, and therefore draw attention to shifting relationships between trust, confidence and risk. The expression of trust in these accounts are best seen in contrast to expressions of confidence, which is displaced for some women through the experience of screening. Concomitantly, the expression of trust, must be seen as a form of agency which presupposes risk (Luhmann, 1988).

Risk is an emergent theme in relation to the sociology of the body, which stems from the influence of the work of both Beck (1992) and Giddens (1990; 1991). Theoretical issues derived from this work are concerned with the intensification and multiplication of social and individual risks as a consequence of modernisation processes. Risk is conceptualised as ubiquitous, embedded in the environment, technology and pollution (Beck, 1992). Arguments about the ubiquity of risk stem principally from observations about the nature and direction of science, technology and contemporary medicine, where the risks of technical and expert knowledge are not perceived to be limited to time and space (Beck, 1992). Risk is seen as out of the individual's control, and for Beck, in particular, risk sustains social dependence on scientific institutions and expert knowledge, as risks are increasingly diffused, globalised and generalised.

However, risk is also perceived as context specific, developed through calculations derived from psychological models of health behaviour and cognitive appraisals, for instance, in relation to health. Here, medical culture is seen as contributing to the generalisation of risk, through, for

instance, risk assessments, diagnostic techniques and the capacity to visualise the unseen (Turner, 1995), and to wider processes which seek to remove the unpredictable and the uncertain from everyday life (see also Ritzer, 1993). For instance, Armstrong (Armstrong, 1995) identifies the uncertain in his most recent work which argues that the medical gaze has shifted from a focus on individual bodies towards the social spaces between 'individuals and each other and between individuals and the socially engineered environment' (Ogden, 1995, p413).

For Armstrong, surveillance in the late twentieth century 'clinic', has shifted from 'surface' to 'depth', in ways which identify the potential for disease in the social spaces between bodies (Armstrong, 1995; but see also Stafford, 1991, who links the desire to visualise the unseen to post-Enlightenment epistemological processes which cut across both art and science). This potential is constructed by taking the previously discrete elements of signs, symptoms and disease and subsuming them under 'factors' which predispose particular bodies to disease. Such factors point to the extracorporeal spaces in which 'lifestyles' are created, as the precursors to future illness (Armstrong, 1995, p400). The use of risk in the identification of potential disease, therefore 'opens up a space of possibility' across space and time. Therefore, in this approach, risk has a functional value in sustaining surveillance.

Whilst Armstrong's work, and that which follows from it, makes significant connections between risk and surveillance, it makes a number of conceptual leaps, which require empirical substantiation. First, Armstrong primarily locates the identification of risk extracorporeally, or in the social spaces between physical bodies, thus drawing heavily on Beck's notion of ubiquity. However, as has been noted elsewhere (Nelkin and Tancredi, 1989; Lupton, 1995), and as I have pointed out in Section Two, the identification of risk in late modernity has also been located within the internal spaces of individual bodies, as Armstrong himself implies, in his use of 'surface' and 'depth'. Diagnostic testing is premised not only on the identification of 'lifestyle' as the space in which disease emerges, but also on the localisation of lesions within internal body space, as the site of potential disease. Chapter Three has developed this argument and suggests that the surveillance machinery which monitors 'normality' identifies the

potential for disease within the internal spaces of individual bodies. This is most clearly seen through a consideration of gender and the status of the female body in the wider construction of 'risk'.

Second, observations of medical practices, set in a health care context which produces and reinforces prevention as the basis of state intervention, tells us more about the mechanisms through which surveillance is delivered, than the transformative power of surveillance in relation to identity. Recent work on risk and the development of risk consciousness, suggests that a consequence of the regulatory impulse in late modernity is the constitution of a new subject identified as a 'controlling self', a 'risky self' (Ogden, 1995, p414), or a 'health promoting self' through which people have some awareness of the responsibility to care for themselves (Rose, 1990; Armstrong, 1993). Ogden (1995) argues, that identity in psychological thought places emphasis on the constitution of individual identity as a compartmentalised and intra-active identity: one with agency and intentionality oriented towards inner correction and control. As the previous chapter suggests, this notion of a 'risky' or controlling self, overlaps with neo-liberal notions of governance through the market and choice.

Whilst it may be the case that contemporary medical practice is characterised by a new trajectory of surveillance, as I have argued in Section One, observations about practice cannot reveal the *experience* of surveillance in ways which inform us about identity transformation either across historical or biographical time. Therefore any analysis of surveillance as a new form of medical practice based on the observation of normal populations must also be grounded in an analysis of the experience of surveillance. Arguments about the expansion of surveillance and the ubiquity of risk are arguments about historical time, where surveillance is understood as a qualitatively *new* form of medical observation and practice, and the nature of risk in late modernity differs substantively from risk in premodern eras (Giddens, 1990), although there is considerable debate about this conceptualisation of the changing nature of risk. However, I suggest that a significant oversight in this version of arguments about both risk and surveillance is that of *biographical* time. By exploring the experience of screening within and across individual

biographies, it is possible to build up a more substantial picture of the nature of both risk and surveillance.

Whilst the manifest concern of theoretical and conceptual work on risk and trust is not embodiment, it nevertheless has potential for locating the conceptual status of the body more clearly. As I have argued in Section Two, risk construction and deployment is central to preventive discourse, as others have noted. Following Beck (1992), Lupton (1995) has argued that diagnostic testing should be viewed in the logic of risk discourse, where the pursuit of progress creates new hazards and individuals develop a heightened consciousness of them. Lupton further suggests that statements about risk are moral statements (see also Douglas and Calvez, 1990) which address both external and internal conditions, such as the environment and health. Diagnostic testing should be seen as a:

'strategy adopted to deal with both externally and internally imposed health risks, by identifying those who harbour the potential to develop a certain condition or disease...and then rationally dealt with.' (Lupton, 1995, p78)

Here diagnostic testing, or surveillance, and risk are seen as synergistic, in the sense that individuals are categorised in terms of risk and the data produced through monitoring 'at risk' populations is fed back into risk assessment. The links drawn here between surveillance and risk undoubtedly develop Beck's analysis in relation to individuals and pose a valuable distinction between external and internal risk. Armstrong (1995) too develops this line of thought, and it has been articulated elsewhere (see Shilling, 1993; Castell, 1992), in relation to prevention (Nettleton, 1992). Within preventive discourse, unpredictability within individual bodies is anticipated, through health check-ups and diagnostic techniques, which identify 'factors' rather than individuals. Surveillance is therefore reworked as the systematic anticipation of the unpredictable, in which expert knowledge is a crucial component.

However, this model presupposes the relationship between surveillance and risk by assuming that risk precedes the impulse towards surveillance, and by implying that surveillance should be seen as a professional response to expert knowledge about risk. In contrast, and in keeping

with my argument in chapter Section Two, I argue that risk should be seen as a product of the embodied negotiation of surveillance. First, however, I discuss how boundaries between confidence and trust are articulated and negotiated.

Confidence, Trust and Embodiment

'Well women' and unreliable bodies

As Section Two has outlined, abnormal cells are cytologically identified and translated into grounds for clinical intervention, in terms of either further examination or treatment. The meaning, however, of an abnormal smear within this discourse, is often ambiguous in terms of whether it signifies the presence or absence of disease: such ambiguities also represent uncertainties in medical knowledge (epidemiological, clinical, pathological) in which the boundaries between disease and not-disease are blurred. There are tensions in clinical categorisation in which it is unclear whether an abnormal smear signifies potential disease or disease in place, and indeed in which the absence of abnormality is not automatically taken by women as an indication of normality. The blurred nature of these boundaries is at least acknowledged within expert discourse, if not communicated more widely. However, these boundaries are interpreted as problematic by women who participate in cervical screening and are told they have abnormal smears.

The interventions made necessary by the identification of abnormalities through the screening process, produced, for some women, trust in their own body through (re)kindling a consciousness of that body. This is particularly marked in the accounts of Jane (62) and Margaret (59), who described a transformed sense of embodiment associated with the discovery of an abnormal smear, and the treatment process this entailed. Both women describe their experience of cervical abnormalities and interventions and their retelling draws attention to the ways in which confidence in their sense of embodiment is displaced and trust in medical power/knowledge emerges, and to their initial resistance to cervical screening participation.

The process of screening forced both women to consider their sense of embodiment in ways which they had not done for some time. They defined

themselves as post-menopausal, and both experienced post-colposcopic bleeding which they described as distressing. Through their experience of screening, they were reminded of the centrality of the management of menstrual blood in women's lives. Their sense of biological, or reproductive time, was disrupted through the process of screening and they were forced to manage 'menstrual' bleeding in ways which disrupted their sense of embodiment.

Jane was initially resistant to the idea of participating in screening. She had her first ever smear three years prior to her participation in the study and her identity as a reluctant participant is summarised thus, as she explains her response to a letter inviting her to visit her general practitioner for a smear test:

Jane Extract 1: TU 22-23

- 01 I thought, cheek, damn, I'm no going for a smear...
02 I couldn't go, going down there for the doctors to look at...em
03 in all honesty, I never gave it a thought that I should go.
04 Nobody ever said to me 'how about a smear test?'
05 or anything like that. I mean my youngest is 29 in June.
06 I don't know, a smear test never, ever came into my head.

Jane's identity as a non-participant is framed both in terms of not wishing to reveal her body to doctors and medical knowledge and in terms of having reached a point in her life course 'beyond' such examinations [04-05]. Her reference to her youngest child highlights how she has considered herself 'beyond' this kind of examination. Here she draws on a denial of reproductive embodiment to explain her avoidance. Despite the pain and discomfort experienced by Jane, she was adamant that she would not only continue to participate in screening until she reached the age limit at the end of the target range, but would pursue screening beyond this limit, which she saw as being imposed on her. Jane expressed this fervently first in relation to the frequency of screening and second in relation to what she would tell other women about screening.

Jane Extract 2: TU 21; 63; 67

- 01 I would tell everybody to go and have them, I really would.
02 Especially when you experience a thing like that.
03 [If Dr. Brown was to say to me
04 'we want you in every six months or a year', I would go 'oh, yes'.

05 I'd tell anybody - I mean anybody - to go.
 06 Definitely, yes..

[

07 Oh I would tell her to go. Oh god...everybody...
 08 certain people I've spoken to have said 'I'm going for a smear'
 09 and I've said 'go, please go'. Definitely I would say go, yes.

Similarly, Margaret's perception of bodily change is heightened through the experience of screening. As I discussed in Chapter Five, her sense of embodiment as a *well woman* was transformed to a sense of unreliable embodiment through the process of screening participation. Whilst for some women, routine monitoring was linked to reproductive health, for Margaret, such monitoring was also linked to perceptions of a 'changing body'. However this monitoring also disrupted her sense of embodiment as a post-menopausal woman (*I thought, here's me, with sanitary towels at my age!*). Not only was it a shock for Margaret to experience bleeding after the menopause, but the amount of bleeding took her by surprise.

Margaret Extract 1: TU 94-98; 144-187

01 I think that's why I was so distressed at 6 o'clock last night
 02 I had to keep changing them - I'm not kidding,
 03 I thought 'all this blood, where's it coming from?'.
 04 But what was going in there, I realise now
 05 it's because of what she was doing inside me.
 06 I think that's what distressed me.

Here we begin to see how a changing perception of her body impacts upon Margaret's understanding of screening. Part of Margaret's initial resistance to screening comes from her sense of embodiment as a *well woman*. Examination and treatment within the context of cervical screening disrupts her sense of embodiment, and continuity between body and self. Her language becomes more distanced in response to the experience of bleeding (*where is all this coming from?* [03]).

The participation of Jane and Margaret in cervical screening, and their retelling of their experience of abnormal smears, highlights the way in which they locate themselves as agents claiming social membership through a transformed sense of embodiment. Furthermore, both women move from a sense of embodiment as *well women*, which they deploy to place themselves outside screening, to a sense of embodiment as *well women* firmly located within screening. Therefore they move from a

sense of embodied confidence, located outside surveillance to a sense of embodiment within surveillance, in ways which also engendered a new trust in knowledge and expertise. Some liberal feminists interpret the accounts of women who see themselves as 'beyond' screening as an expression of an absence of care of self. The accounts of Jane and Margaret suggest an alternative interpretation in which such statements express an initial sense of confidence in embodiment. However, this is disrupted through the process of screening, in ways which produce an emergent trust in expert knowledge which reinforces the need for self-surveillance.

Shifts from confidence in embodiment to trust in expert knowledge are similarly evident in other women's accounts, where such a transformation can also be read as the emergence of self-surveillance. Rose, a long-time participant in cervical screening, indicated that her experience, which included ongoing abnormalities and interventions over a period of about two years, had engendered a thoughtfulness and consciousness about her body which had previously been absent. She began to interpret her body in ways which actively produced new knowledge about it, which she used as a resource and which contributed to self-surveillance. For instance, she described how she began to be watchful and record bodily signs. She said:

'I suppose I became more careful and I pay attention to things. If necessary I take any notes of any funny things that happen, just so that I can remind myself when I do see somebody...' [Rose TU 422-425]

Alice also pointed to the ways in which she became aware of her body's limitations. Reflecting about the ways in which her experiences had affected the way in which she thought about her body she said:

'I want to be kinder to my body. I'm more aware of abusing my body, therefore I try to be positive about it. I'm better physically. I try to care about it and have to look after my body...My body has limitations I hadn't really considered before. And I think there might just be some things that medicine can't do anything about.' [Alice TU 135-137; 168-169]

Not only could confidence in embodiment be displaced through the experience of screening, but also confidence in expert knowledge. Mary had experienced a long period of stomach complaint prior to, and alongside, her participation in cervical screening and colposcopic treatment for a cervical abnormality. She was divorced from her husband and dated the emergence of the stomach complaint from the time of her marital breakdown. She expressed anger over the inability of medicine to accurately diagnose the complaint and find a solution to her problem. Her perception of this inability as an unwillingness to accept a relationship between social circumstances and physical ailments had the effect of undermining her trust in the practices and power of medicine in general. In Chapter Five, I discussed how Mary was drawn into screening despite her distrust in medical culture and her representation of herself as a sceptic. Her experience of screening reinforced this scepticism and absence of trust. For instance, she said:

'You get the smears, smears normally come back normal. I've had two sets of treatment at this hospital, so how does the smear come back normal when six months later I have to get another set of treatment?' [Mary TU 58-59]

As she recalled her experience, it seemed to her that she had received treatment for cervical disease *despite* having normal cervical smears. She found this puzzling to say the least, and her perception underpinned an absence of confidence in expert knowledge. Furthermore, this perception raises issues around the status and levels of knowledge in the context of screening participation. There are different ways of interpreting the perceived disjunction between the experience of normal smears and the experience of treatment.

First, it is possible that Mary received treatment but her smears were not, as she thought, 'normal'. Rather they indicated, for instance, mild forms of dyskariosis or some other form of borderline change. The misapprehension arises in her interpretation because she has not been given this information or has been unable to understand the information she has been given. Second, it is possible Mary received treatment, although her smears were 'normal,' because clinical, colposcopic observations of her cervix were judged to be more revealing than

cytology reports. It may have been that problems were identified colposcopically which were not evident in the smear itself. Indeed, colposcopists in the clinic I observed said that they would discount a borderline cytological report if a cervix looked 'suspicious' upon clinical examination. In this way, they prioritise clinical judgement over laboratory science. A third possibility is that Mary misunderstood the nature of examination, and interpreted colposcopic examination as 'treatment'. Examination involves 'painting' the cervix with dye which will show up problem areas. This physical contact with the cervix might make it difficult to make a distinction between examination and treatment. Even where women had been offered the opportunity to observe examination via a television monitor, the procedures which were being carried out were at times indistinguishable as examination and/or treatment.

It is possible for any of these interpretations to be valid. However, for Mary, the valid interpretation is her sense of puzzle, the way in which this highlights blurred boundaries between normal/abnormal and the displacement of confidence in expert knowledge which this confusion reinforces. For Mary, the timing of the normal/abnormal sequence seems out of kilter in her understanding that she has 'treatment' in the context of a normal smear. This compounds her sense of distrust in medical knowledge and practice. Mary's account reveals a paradox: on the one hand, her sense of embodiment is discounted as expert knowledge is unable to identify the source of her stomach complaint, which she identifies as a significant aspect of her embodiment. Taussig (1980), discusses this kind of expert discounting. On the other hand, Mary also experienced what she perceived as treatment for a condition of which she had no embodied knowledge. She felt physically well, yet she was defined as potentially diseased. The identification of potential disease raises questions for Mary about her sense of embodiment and her account draws attention to the ways in which this paradox contributed to the displacement of confidence in medical knowledge. She is moved to actively (re)interpret her body as a consequence of her screening experience and the knowledge ambiguities which this engendered.

Mary's experience prior to screening participation had already contributed to a partial displacement in confidence in expert knowledge. Her explicit distrust was unusual in this sample of women, who otherwise indicated an initial degree of confidence in medical culture, knowledge and practice. Yet the way in which she expresses and deals with her absence of confidence has similarities to those of other women. For instance, the accounts of some women express tensions between confidence and trust. After her experience of examination and treatment, Claire felt she was:

'left to sort it out herself' [Claire TU 33-34]

Others said:

'I didn't find the doctor - my family doctor - that helpful, when I went to see him first off. He just more or less brushed it off and said "it's just one of these things." That was it.' [Lorna TU 89-90]

'I don't think we were given particularly that much information, like, em...especially when I was told my smear was irregular. I was just told, like, you get a wee card or a slip of paper saying "your smear is irregular."' [Chris TU 50-52]

'I never felt that there was, like, a follow-up actually explaining to you what the abnormality was. To me they should have had on that slip, "please come round and see me" or something like that so they can explain about this abnormality. But there was nothing like that at all.' [Susan TU 32-33]

'They've had a smear that wasn't quite normal. Sometimes I feel they're a wee bit shady about that and you wish they would say just how abnormal it was...' [Ivy TU 20-21]

Finally, a more explicit statement which expresses a displacement of confidence:

'Anyway you have to trust them because you don't know what they are looking for, so I was compliant with them.' [Nicola TU 20-21]

These statements point to the limited information with which women are supplied both by their own doctors and in written form from clinics and

laboratories. Statements such as these are similar to findings from other studies which have examined women's knowledge and attitudes towards cervical screening. Such findings are typically used to point up poor communication skills and gaps in women's knowledge which need to be addressed, as I discussed in Chapter Four. Drawing on my discussion in Chapter Three, however, I suggest that these statements also tell us about the problematic nature of knowledge in relation to cervical screening, and the role of trust in sustaining participation. All of these statements draw upon an assumption that medical knowledge is governed by certainty, but that such knowledge is not shared amongst the public. All of the statements imply that if doctors shared their knowledge, this would help women to better understand their own sense of 'trouble'. However, as Nicola's comment implies, it is precisely the absence of such information which, in the cases of these women, secures compliance and participation. Because the nature of the knowledge held by women is uncertain, and confidence in their sense of embodiment becomes displaced in the process of screening, trust becomes a necessary component of such participation. The statements presented here support Luhmann's (1988) observation that the expression of trust must be seen as a form of agency which presupposes risk. It is, therefore, to the articulation of risk that I now turn.

Knowledge, Ambiguity and Risk

Internal Vulnerability and Risk as a State of Being

As my discussion in Section Two suggests, cervical screening has been subject to a discursive shift from diagnosis to prevention, and is currently formally understood as an objective process through which 'precancerous cells' are detected. Furthermore, I have described in Chapter Four, how cervical smears operate as risk markers, by highlighting the potential within particular bodies to develop disease. In what follows, I will develop the notion of risk as a product of surveillance in two main ways. First, the theme of internal vulnerability is articulated by some women, as an explanatory model for disease causation, especially by those women who draw biographical links between themselves and other women with cervical abnormalities or of other forms of cancer. The idea of *being in a state of risk* underpins the interpretation of cervical abnormalities for such women, in ways which redefine boundaries between health, wellness

and disease. Second, the perceived ambiguities of external factors such as the nature of medical knowledge, underpin a sense of *being at risk*. Women articulated risk as they described their views about the organisation and delivery of screening in ways which identify uncertainties in the abstract system of which cervical screening forms part. Finally, I will conclude my presentation of interview material with a discussion of these articulations of risk in relation to sexuality.

A sense of internal/intrinsic vulnerability emerged in connection with the ways in which women linked their own screening biographies with those of other women. Often, like expressions of obligation, such linkages involved identifying sisters, friends and mothers who had either experienced cancer of some kind, not necessarily directly linked to the reproductive system, or who had experienced cervical abnormalities, and in some cases, death. Having knowledge of other women's experiences, intensified a sense of internal vulnerability for some women. For some women, perceptions of disease were articulated in terms of inheritance or personal experience, where women knew other women who had either experienced abnormalities themselves, or some form of gynaecological disease, including cancer. Four women in the study had experienced the loss of a mother, a sister or a friend from cancer: one specifically from cervical cancer and three from gynaecological cancers. Almost all of the women knew someone connected to their social network who had experienced colposcopic examination and treatment for cervical abnormalities.¹ The women themselves thought this odd, and attributed it to a much wider prevalence of cervical disease than was epidemiologically apparent, and indeed this perception intensified a sense of female embodiment as being in a state of risk.

A common perception amongst many women in this study was the way in which cervical abnormalities were understood as latent properties of the female body, as already in place within the female body (in contrast to the dominant medical view of cervical abnormalities signifying potential change within the cervix). Consequently, cervical screening, and

¹ Davison, Smith and Frankel (1991) draw attention to this phenomenon of being able to identify others within or just beyond their social network, who have experienced disease or misfortune.

particularly the smear test itself, was seen as a safety mechanism which would reveal this property, and open up potential for re-establishing certainty. Comments about limits of the body included the following:

'I know...em...how can I put this? I know what good comes out of them getting done at regular periods, you know? Even if it is only every three years, you know that they are keeping a check on you and if there is anything...what they can pick up at the time. So I know the whole point of it is...obviously for your own sake...if there is anything there, as the doctor says, if these things are left alone, in years to come they can turn into nasty things.' [Carol TU 25-27]

'...it's made me more aware of cancer, and it's sort of made me feel that I have to have the checks. I'll always have the worry that I'm going to have cancer and I worry even more because my mum had cancer...' [Fiona TU 178-179]

'...if I want to have a smear when I'm over sixty then I'm quite within my rights to have one, aren't I? That's everything, because I'm going to keep having a smear test because...when you become sixty, that's you finished...what happens after that if something goes wrong?' [Margaret TU 612-616]

What such comments have in common is the way in which they draw on ideas about the female body as having limits and how they link this idea biographically to their own and other women's experience. They perceive the limitations of the body but do not place such limitations beyond the reach of medical knowledge. Instead, for them, their perceived vulnerabilities can be actively addressed through increased self-surveillance. These women draw on their own sense of vulnerable embodiment as a resource which grounds frequent and regular screening.

The ambiguity of what an abnormal cervical smear means opens up a space for women to construct their own meanings. For Linda, knowledge of an abnormality produced a sense of risk for her, which was then reinterpreted in the light of her gynaecological biography. In discussing her knowledge of cervical screening, she says:

Linda Extract 1: TU 27-30

- 01 I definitely know more
- 02 but I think that leads to more questions in some respect.
- 03 But there's a whole lot of reasons for that,
- 04 one of which is that I've had a lot of infections diagnosed
- 05 like chlamydia and that was really very interesting.

06 Not frightening, a little alarming perhaps
07 when I began to realise
08 the implications of what chlamydia might mean
09 and the fact that those implications were not made clear to me...

Her current abnormality highlighted an uncertain reproductive future in the context of screening which she linked to past experiences. For Linda, her current experience of colposcopic treatment threw into relief what had previously been a fragmented experience of chlamydia. What became apparent for her, in the light of her current experience, was a connection between her sexual health in the past, and her potential fertility. Her present experience of screening foregrounded these connections and for her, created uncertainties which were embedded within the uncertainties of an abnormal smear. To a degree, she understood her current abnormality as a consequence of repeated chlamydia infections, which in turn raised the possibility of affecting her fertility. What seems apparent in this extract is the way in which biographical linkages are created between different aspects of embodiment in ways which cause Linda to question her reproductive future.

Fiona drew attention to her perceptions of her embodied limitations and the limits of other female bodies.

Fiona Extract 1: TU 178-181

01 ...it's made me more aware of cancer. I'll always have the worry
02 that I'm going to have cancer and I worry even more
03 because my mum had cancer so it really...brought home to me,
04 I thought - oh god - like I will worry and I think I'll be worried
05 for the rest of my life and I often think,
06 if I'm going to die it's going to be cancer.
07 Like, although they say that they've caught it
08 I just know that it's there and it could start up again.
09 I suppose maybe it's a fear I've got...
10 I'll just keep going for smears.
11 Nothing has proved to me that my mum had cervical cancer
12 but it still worries me. If she hadn't died of cancer
13 it wouldn't worry me so much about my smears
14 but then they don't know if it's hereditary or not.
15 But it's still a worry.
16 It's there, it might flare up again,
17 that's why I'd be keen to find out what really causes it.

For Fiona, her mother's cancer and subsequent death operates as a strong incentive to monitor her own body through screening participation. She

linked a sense of latency posed by an abnormality to the death of her mother, from cancer [01-06]. She perceived cervical disease as an ever-present property of the female body which could 'flare up' at any time [15-17]. This possibility was intensified through the fear articulated by Fiona, as a consequence of her mother's death, a fear which lay dormant until her own abnormality was detected [11-15], which I discussed in Chapter Five. For Fiona, the notion of cervical disease in terms of latency is inseparable from her memory of her mother's death [04-06]. Her account is framed in terms of a potential with which she lives in the present, or in terms of risk as a state of being.

Since screening is seen as a technique which reveals latent disease, where cervical disease is perceived in terms of latency, or internal vulnerability, women who do not participate in screening are seen as placing themselves *at risk*. This view draws on a rational discourse relating to both the availability of technology and the perception of that technology as an objective and truthful measure of the existence of disease. For example, both Mary and Chris understood the smear test itself as a window of opportunity on a disease process which can be controlled by medical intervention and which offers certainty. For instance:

'If they catch you quick, there's something they can do.'
[Mary TU 50-51]

'If you don't have a smear, the worst can come to the worst.'
[Chris TU 50-51]

A certainty posed by intervention or external control is expressed here, particularly by those who knew other women who had experienced either abnormalities or disease. For Julie, the limits of the bodies of both her sisters is brought into being as she describes her own fears when she learns of an abnormal smear. Julie says:

Julie Extract 1: [TU 76-78]

01 I was a bit worried because I have two sisters
02 and they both have problems with their organs
03 and one of them actually died of a tumour,
04 but it started in her womb
05 or ovaries or whatever. It may not have had anything to do with it
06 but I thought, oh my god, here I go again,
07 or here someone in the family
08 goes again and this time it's me. My other sister had something

09 a few years ago as well. So I guess I'm a bit more sensitive to it as,
10 well, possible.

Julie perceived her own cervical abnormality as latent cervical disease, in part because she could link her experience with the gynaecological disease and subsequent death experienced by one of her sisters [06-09]. She expressed a tension between her perception of latent disease and the potential for disease [01-03]. Her account expresses an uncertainty in the boundaries between the notion of latent disease and that of disease potential in ways which parallel the professional debates I outlined in Section Two. These boundary uncertainties are similarly evident in the accounts of other women who emphasised participation as a strategic response to the uncertainty posed by abnormal smears.

Ambiguity also affected women's experience of screening in ways which produced risk in terms of the timing of smears and examinations. Liz has never had colposcopy, but has had a number of abnormal smears over a period of two years. She has moved between normal/abnormal smear categories over this period. The meaning of abnormality for her was ambiguous, but she thought a means of negotiating this ambiguity could be by having further investigations. She expressed a desire for colposcopy in order to confirm a particular sense of embodiment, since what she otherwise experienced was a kind of liminality (Posner and Vessey, 1988, also provide some discussion of this experience). Whilst screening rhetoric is framed to confirm well woman identities (see Chapter Four), for Liz, the movement between normal and abnormal smears forecloses this sense of embodiment, which is framed by uncertainty. Medical discourse could not locate her as a well woman, nor as a female body potentially at risk of cervical disease. Nonetheless, Liz perceived further examination and treatment as one means of establishing certainty. She said:

'I suppose it makes you think that things can happen like that and it makes you more wary and makes you just go and have regular smears and checkups.' [Liz TU 77-78]

For Liz, uncertainty and ambiguity produced an altered sense of embodiment which could be described as being in a state of risk. She

looked to an 'objective' technique, such as colposcopy, to help her (re)establish a sense of embodiment and therefore of certainty. Participation in screening both produces a sense of vulnerable embodiment and forms a source of protection against it. Yet, for some women, even further examination and intervention, as a means of establishing certainty, can reinforce uncertainty and ambiguity. Ivy's account illustrates both how further investigation reinforces uncertainty and ambiguity and the sophisticated nature of understandings which women may hold of health and disease.

'I mean there's things you can do to prevent like, heart disease. You eat less chocolate, and smoking and exercise and that. But I think there's some things that the investigation into isnae that far developed that they can actually say what causes it, or they can isolate the thing, the cause. So I think it's maybe one of these things. They haven't developed it that far yet that they can actually put it down to either A, B or C. And they investigate you and put you into one of these categories...I think it's just one of these things where you have to take your chance and some will get it and some will not'. [Ivy TU 58-59]

Ivy expressed different notions of disease and individual response to them. On the one hand, she linked heart disease to personal responsibility and identified practices and actions which she perceived individuals might take to minimise its onset.² Heart disease in this account is clearly linked to lifestyle. In contrast, she neither perceived cervical disease in terms of latency, nor did she see it as the consequence of behavioural or lifestyle choices. Rather, she mobilised an understanding of disease as fate, as outwith the control of individuals or expert knowledge systems, as *just one of those things*, currently for which there are no rational solutions. It is this understanding which appears to inform her sense of uncertainty and points to risk as a state of being.

The knowledge which women develop in their experience of an abnormal smear, points to risk as a state of being which is linked to the intrinsic

² Davison, Smith and Frankel, (1991), *ibid.*, also provide a typology and perceptions of 'candidates' which individuals use to identify those likely to develop heart disease. Ivy's complex understanding of different kinds of disease turns the notion of candidate around to suggest a typology of diseases which are characterised in terms of how individuals might be expected to respond to them.

processes of cervical screening rather than to extrinsic processes such as sexual activity or smoking. When faced with such an abnormality, female embodiment is interpreted as neither healthy nor sick; neither diseased nor free from disease. In the perceived absence of expert certainty, ambiguous knowledge underpins a sense of risk in terms of potential changes in the experience of current and future states of health. Being in a state of risk therefore grounds cervical screening participation for some women. As Gifford (1986) outlines in relation to breast cancer changes which are similarly ambiguous:

'What was once risk is now an experienced present. Here, risk loses much of its unmeasured uncertainty. Risk is certain and rather than experiencing 'being at risk', women experience 'risk'.' (Gifford, 1986, p233)

As Section Two describes, debates within medicine and its ancillary specialisms have recurrently engaged with the issue of cervical disease classification and development. The construction of cervical disease as a linear process which requires surveillance allows the possibility of gynaecological interventions which are presumed to halt, reverse and eradicate disease. Many women referred to cervical abnormalities as indicators of disease, understood as a linear process, and to screening as a window of opportunity on a what is seen as a progressive disease. However, abnormalities were also ambiguous for many women, in ways which produced uncertainty and a sense of being in a state of risk.

The ambiguities embedded within the construction of knowledge around cervical disease constitutes a social space in which multiple risks can be identified both for and by women. It is this ambiguity, especially, which underlies the ways in which women themselves contribute to the process of identifying themselves as being in a state of risk. However, whilst abnormal smears, for many women, represented ambiguities, for some, there were certainties to be salvaged. Women drew on this sense of being in a state of risk in interpreting their participation in cervical screening and in doing so, perceived screening itself as a means of reintroducing a sense of certainty. Whilst further intervention could produce both a sense of certainty and of agency, by 'doing something', increased external control over a sense of vulnerable embodiment was

also linked to the displacement of confidence in expert knowledge. Hence the experience of screening contributes to a reordering of time in which the potential for future disease is brought into the present. The cervix is therefore understood as a site of transformation: of cells from normal to abnormal; and of states of being.

External Ambiguities: Being at Risk

Managing the Absence of Certainty

Nicola had a smear abroad in the context of a routine gynaecological examination. This was normal, nevertheless, in a gesture of refusal against its expected normality, she had a repeat smear upon her return to Britain, 'just to make sure'. This smear was abnormal and colposcopic examination followed, with a period of treatment. In a short space of time Nicola's smear status moves from normal to abnormal. Whilst this transition is explained to Nicola in terms of a 'false' negative, the distinction between a normal and abnormal smear presented a problem of evaluation for her. She refused to believe the expected outcome of a normal smear, suggesting a displacement of confidence in expert knowledge and a sense of uncertainty which grounded her 'just in case' strategy.

Similarly, Diane's (27) first smear was in the context of joining a new general practice. When asked about her previous contact with health services she indicated that she had had the 'usual things' and that she had 'been going for smears regularly'. However, her 'regular' participation was not on the grounds that her smears were normal. On the contrary:

'I had to because my cells weren't normal. Or they weren't taking proper readings or there were discharges that they weren't happy about. *So they never found anything too bad but I had to keep going back.*' [Diane, TU 19-20, my emphasis]

When asked how she responded to this and what she thought it meant:

Diane Extract 1: TU 23-24

- 01 What did it mean to me? Obviously I know a bit more about it now
- 02 than I did then so I can't really remember at the time.
- 03 I remember the first time I was told I had abnormal cells
- 04 I was really worried about it - I think I was about 20 or something.
- 05 I couldn't...I thought, what does this mean,

06 does this mean I'm going to get cancer if they don't get rid of them?
07 I didn't really know that it was harmless at that time,
08 that it could go away, until it was explained to me.
09 I did know that it was going to test my cells
10 to make sure that everything was OK.

This account develops a sense of negotiating ambiguity [01-02]. Diane holds different levels of knowledge about the meaning of screening [03-06]. On one level, she reproduces a conventional medical discourse that smears are to look for abnormal cells, which were found many times, in her case. At another level, she draws on a discourse of ambiguity in which there is less certainty about the significance of abnormal cells [07-08]. They could potentially signify cancer and Diane considers this possibility. Alternatively they could be 'harmless' and a 'normal' aspect of embodiment which might simply go away. She alludes to this earlier when she says that despite the fact that 'they never found anything too bad' she had to keep participating in screening. So there is uncertainty at this level of knowledge about what the abnormalities mean and it is this which provides the basis for her participation.

Uncertainty was similarly evident within the accounts of other women in this study. In this case, however, uncertainty was linked to a sense of being at risk from knowledge ambiguities, policy exigencies and administration errors. For some women, there was a tension between on the one hand, an acceptance of the necessity of screening and their obligation to participate in screening and, on the other, a perception of being at risk from that very process.

For instance, Teresa (40) was sceptical about current screening policy recommendations. She described her screening participation in terms of having:

Teresa Extract 1: TU 75-86

01 Em...probably quite a few, because after about 34
02 I tried to make sure I had a smear approximately every year.
[
03 AH: Is that something you initiated yourself?
[
04 Yes. I had a friend and colleague who...em..
05 eventually was diagnosed as having cervical cancer
06 but by the time the diagnosis was made it was very advanced

07 she subsequently died within a year.
08 Soon after that I did make a very positive attempt
09 to have a smear...em...regularly, particularly...
10 certainly no less than once every two years, although I realise
11 that the recommendation is once every three years.

She did not think that three yearly smears were sufficient [08-11]. Her view was strongly influenced by the death of a friend from undiagnosed cervical cancer [04-07]. She therefore attempted to obtain smears on a more frequent basis. Teresa suggested that she had no problem in obtaining smears. Almost immediately however, she acknowledged that whilst she had 'no problem', this was a consequence of a strategy of shopping around for smears from different venues, such as from her general practitioner, family planning and well woman clinics. When asked if she thought that there *might* be problems in obtaining a smear, she explained:

..because I had discussed it with my doctor at length when we were discussing it in an overall political sort of way about funding, and funding for cervical screening, and weighing that up against other sources of cost in the health service and, you know, that fact that it wasn't necessarily a very reliable procedure, there are false positives as well as false negatives. So that did enter my reluctance to go to my GP...that GP, who has since changed.' [Teresa TU 111-118]

Teresa perceives that her general practitioner might be reluctant to give her a smear test 'on demand' on two counts. First, the financial cost involved might prejudice him against doing this particularly in the context of funding changes in which there is no financial incentive for general practitioners to recommend screening more regularly than policy guidelines suggest. We might interpret this as a reflection of the way in which practitioners themselves are subject to surveillance by the state. Therefore, Teresa perceived her general practitioner as unsympathetic to her need for more regular screening. Second, Teresa raises questions about the degree of reliability of the test.

Other women expressed similar anxieties about both the reliability of the test itself and the timing and regularity of smear tests. Linda, for instance, recounted her puzzlement over the smear test itself and the kind of information it provided.

'..how many different sorts of smear tests can you get? What's the story? Can you test for all the different sorts of things you might be looking for from one smear or do you need to take smears from different areas? I don't know actually how smear tests work, whether one is taking a sample and its that which is tested or whether there is something important about the thing you use to take a sample with...so is it something like Ph papers are you getting a different...could you get different smear tests? What is a standard smear test, is it just checking for...what? How many different things, I mean, also now with screening done on HIV is that something that is done as a standard and if so it would surely be a good thing to know about it...that's going into another issue. In a nutshell, with a smear, how many things can they test for and how many things do they routinely test for?' [Linda TU 34-35]

In some cases, women had experienced what they perceived as errors and mistakes in the taking and reading of their smears. Fiona for instance, recalled how she had been informed of her smear status, only to be informed later that this was incorrect.

Fiona Extract 2: TU 144-145

01 I went to the doctor's and I got a letter the other day
 02 saying I was due a smear and I just ignored it
 03 because I got one six months ago.
 04 But I went to see the doctor for something else and she says, weren't
 05 you due a smear because the last one was slightly abnormal?
 06 I says I thought it was clear again.
 07 You get a slip of paper telling you that it's abnormal,
 08 and I said there it is - it's normal.
 09 So the doctor said, 'well they read it wrong'. So I was really worried.
 10 I got the smear and they wrote back and said it was an error.
 11 I couldn't believe it. I thought they were hiding things from me.
 12 She reassured me that it was normal,
 13 she said it was a doctor that was only there for so long
 14 had made the error.

Fiona was reminded to have a smear, which she ignored because she had had one in the previous six months [01-03]. She understood that this smear had been normal [06], yet her doctor observed that in fact it had been abnormal [04-05] and the information she received had been incorrect [09]. However, following the second smear within a six month period she was then informed that the abnormality was the wrong reading. Her initial response to this contradiction was to think the worst and that she was not being told the truth, rather than as a result of professional incompetence. Consequently, the expected outcome of a normal smear is

disrupted here and in its place an understanding of being at risk develops, first from perceived misinterpretation and second from administrative error.

Fiona's sense of being at risk stems from her observation here that the certainty which screening potentially provides has its own internal limits. This extract expresses a dialogue between different forms of local knowledge. The doctor advises Fiona that she needs another smear because her previous smear is abnormal, indicating the possibility of underlying pathology in her cervix. Fiona however, counters this with her own knowledge of a previously normal smear. This is discounted in the exchange with her doctor who informs her that the knowledge which Fiona thought she possessed is mistaken. At this point, the doctor indicates that there are interpretive issues at stake (*they read it wrong* [09]). The way in which interpretation is individualised is significant because this deflects attention from any structural problems and locates the problem of interpretation, and therefore the risk of further error, on a particular individual (*a doctor that was only there for so long* [13]).

Fiona responded to this sense of being at risk by increased attachment to screening participation. In contrast to Teresa and Linda, who 'shopped' around for smears, Fiona was active in a local community women's health group which sought to raise awareness of the necessity of screening; provide information to other women in the area about the smear test itself; and support those who experienced abnormalities. One of the ways in which she was able to manage uncertain knowledge with which she was provided was to participate in this group. She said:

'I went to the women's health group so that I could find out more about it...about the cancer subject. But I don't think I could do more than I'm already doing.' [Fiona TU 162-163]

In common with other women, the risk of system error, added to the risk of potentially developing cervical cancer suggested to Fiona that yearly smears would be the optimum frequency for her. Yet even annual smears might be insufficient and she raises questions of entitlement in relation to the timing of smears.

'...I don't know if a year's enough because it was only within the year that I went from nothing to being abnormal. They say it takes fifteen years. If I had left it fifteen years it would probably have been far too late.' [Fiona TU 182-183]

Therefore, whilst there were ambiguities surrounding the knowledge which screening offered, participation was in itself an active measure which an individual could take. Other women, however, perceived themselves to be outside surveillance either because of age. Margaret, for instance, commented on the distinction between policy guidelines in relation to screening in Scotland and her new perception of the need for surveillance.

'Well, when Dr. Paul said to me, you only have to get one now and another when you're sixty and that'll be you. But Alex, who's to say that nothing'll happen after you're sixty?' [Margaret TU 554-556]

As an older woman, she was sensitive to the way in which age defined her entitlement.

'I mean sixty, that'll be your last, that'll be you. Who's to say what'll happen after you're sixty? So I think I myself would go and make another appointment for a smear test even if I'm sixty two, sixty five, or whatever...' [Margaret TU 554-556; 565-568]

Margaret saw herself as being at risk from current policy recommendations. She strongly resisted the rigid boundaries placed around age and said:

'...if I want to have a smear when I'm over 60 then I'm quite within my rights to have one, aren't I? ...I'm going to keep having a smear test because...when you become 60 that's you finished - what happens after that if something does go wrong?...I would like to be positive and know that at least if I had that...' [Margaret TU 611-617]

Whilst Margaret and Fiona connected their own sense of risk to policy exigencies and individualised errors, Sheila's perception of her own experience illustrates the power of risk as a cultural category, which drew its strength from linkages between media reports of a major system error on the west coast of Scotland at the time of interview and personal

knowledge of a neighbour who had experienced an abnormal smear. Prior to the extensive reporting which accompanied what was perceived as misinterpretation at the Inverclyde Royal Hospital, Greenock, Sheila claimed that she had not given her own abnormal smear much thought. Now, however:

Sheila Extract: TU 84-85 'knowing my luck I'll be the one'

01 I sit and think you know, what if this one,
02 if this one comes back and it's normal.
03 I was telling my boyfriend about it last night and he said,
04 'my god, I wish this smear test thing would come through.'
05 He says, 'if it comes back normal you'll be quite happy.'
06 I says, 'aye, but what if it's a mistake?'
07 And he says, 'god, that's only down in Greenock'
08 and I said 'aye, but there's nothing to stop it happening up here'
09 sort of thing.
10 There was a woman around the corner from here a few years ago
11 - she had six kids - and one of her smear tests came back normal
12 so she never thought any more about it.
13 And she ended up getting cervical cancer.
14 And of course by the time she found out she had cervical cancer
15 it was too late. I says, 'what about her around the corner though?'
16 He says, 'aye that's one in a million cases.'
17 'Aye', I says. 'But knowing my luck I'll be the one.'

The story of the 'woman around the corner' operates as a kind of cultural tale here and the category of normal smear poses a problem of uncertainty. The story which Sheila tells frames her own perception of risk and articulates fears which she identifies as part of her experience of screening. Sheila's sense of being at risk from health care incompetencies, is heightened by the panic framework in which much of the reporting on Inverclyde was cast. At the same time, however, the connections which Sheila draws in her account between Inverclyde, the 'woman around the corner' and her own experience of screening links a more general perception of risk to her own circumstances. She reinterprets her experience of screening in terms of the possibility of being at risk: not from cervical disease, but from a failure to detect cervical disease within the system designed to detect it. In turn, the perception of risk produces a sense of resignation, as Sheila says:

'If I got one that did come back abnormal, I mean, there's not really an awful lot I can do about it apart from going and getting it seen to. I've never been one for worrying for what might happen. If they come back well, good, and if one

comes back abnormal I'll just go and get it seen to. You know,
I'll agree and I'll cross that bridge when I come to it.'
[Sheila TU 106-107, my emphasis]

Certain contradictions emerge in relation to risk, which form part of the understanding and experience of screening. Whilst screening offers a safety mechanism which creates a sense of certainty, articulated through notions of the provision of 'peace of mind', the procedures for 'catching you quick' themselves pose risks in their generation of uncertain and ambiguous knowledge. The procedures for detecting potential disease may themselves be fallible, hence the cytological and clinical observations central to screening reintroduce risk by their very incertitude. Not only is there a risk of developing cervical disease, but also, the screening process itself introduces a risk of having disease which may be misinterpreted.

Women contextualise their sense of being at risk. For instance, smear misinterpretations are often placed in the context of a health service under pressure from busy clinics, understaffing, 'cutbacks', inadequate funding, mismanagement of staff or poor organisation. Women acknowledged that it was the role of expert knowledge to police the boundaries between normal and abnormal, but anxieties often emerged around the issue of misinterpretation — 'not seeing whatever it was that was being looked for', or reading a normal smear incorrectly. Whilst the issue of 'false' positives and negatives are addressed within epidemiological and pathological debate, these accounts suggest that both categories of normal and abnormal smears are experienced by women as forms of risk. Responses to this vary, but include the adoption of strategies to counter what is perceived as the risk of system error. For Linda and Teresa, this meant 'availing' themselves of smear tests whenever possible in an effort to manipulate the timing and frequency of screening. For Margaret, this meant initiating smear tests herself as a woman outside policy recommendations. Fiona's response was to meet with other women to share information and raise questions about the timing of screening. For Sheila, accommodating knowledge about system errors and drawing links to her own circumstances produced a 'resigned dependency' of the kind to which Beck (1992) refers.

Hence, screening participation can be interpreted not only as the internalisation of prevention, if at all, but also as an expression of a displacement of confidence in expert knowledge and an increasing sense of being at risk. In this instance, expert knowledge is seen as both a safety mechanism and a problem of legitimacy which in turn, highlights tensions in the boundaries between confidence, trust and risk. Risk can be understood here both as a product of surveillance and as a mechanism which ties women further to its logic.³

Sexual Health and Risk Identities

A final form of risk, embodied in particular social relationships, emerged in relation to sexuality. As Section Two points out, although the construction of women as sexual subjects remains central to current notions of cervical disease aetiology, as education and information literature, as well as the media illustrate, the precise relationship between 'sex' and cervical disease is a further area of contested knowledge. Of particular significance is the way in which the category of 'promiscuity' is used to specify groups 'at risk' of developing cervical disease. The way in which promiscuity is used, both obscures the role of male partners in the development of cervical disease and is under-played by feminists who wish to secure women's participation in screening.

The link between sexual activity and cervical disease was often mobilised and disrupted by the women I interviewed, particularly those who sought to define themselves outside 'promiscuity'. It was also disrupted, actively denied and erased from the representation of cervical abnormalities to women by nursing and medical staff in the colposcopy clinic. This erasure was identified by clinic staff as part of a strategy to 'protect' women from having to deal with the potentially 'damaging' consequences of confronting relationships with male partners. McKie (1996) has recently argued that many women do indeed have to contend with a form of sexual jealousy and confrontation from male partners in the context of cervical screening.

³ (Singer, 1994) provides discussion of a surveillance logic in an 'age of epidemic'.

For instance, nurses downplayed connections between cervical disease and sexual activity, though at times they would appeal to medical discourse and refer to the wart virus (HPV), which as I pointed out in Section Three, has been linked to cervical disease. The charge nurse at the colposcopy clinic noted that she was careful not to mention sex since she felt this might 'alienate' women from both their bodies and their partners. She acknowledged that she might link abnormalities with HPV on occasion but strove not to make explicit links to sexual activity and particularly to 'promiscuity'. I have interpreted this to mean she was not critical of the concept of promiscuity and its gendered implications, nor that the force of its meaning had been challenged by social and sexual changes for women in the last two decades. Instead, she accepted its association with cervical disease, however, she was not prepared to emphasise it for fear of alienating 'clients'.

Managing Contamination and Risk Boundaries

Contamination and pollution beliefs are often associated with breaching boundaries (Douglas, 1970), such as crossing intact skin or particular bodily orifices, such as the mouth (Nettleton 1988), vagina (Caplan 1987; Laws, 1990) and cervix (Thomas, 1992). These kinds of beliefs have been articulated in relation to cervical screening where women have experienced abnormalities (Posner and Vessey, 1988), and also more generally by women experiencing any kind of examination which entails physical contact with a male or female hand (Kitzinger, 1992). Contamination beliefs were expressed in the data I present here in relation to possible causes of cervical abnormalities and, in more general terms, where sex/cervical disease/AIDS/risk were discursively linked together in a way which reinforced an understanding of cervical disease as potentially ever-present and therefore in need of constant monitoring.

Where contamination beliefs were drawn upon to explain the causes of cervical disease, it was understood both in specific terms, as the result of viral entry into the body, and in general terms, as a consequence of 'risky sexual behaviour'. Teresa, for instance, placed significance on a particular relationship which she had recently ended when she was informed of her abnormal cervical smear. She discussed, at length, the possible causes of her cervical abnormality with her gynaecologist, who

had indicated the presence of human papilloma virus. She was aware that its presence did not necessarily explain her abnormality but certainly suggested a possible cause. Teresa commented on the relationship between her experience of screening and her feelings about sex. She felt that, since she had not had sex for some time prior to this relationship, and that although the virus can lie dormant for three to eight years, this man was probably responsible for contaminating her with the virus. She compared HPV to HIV in the sense that it created the same issues around sexual relationships and whether or not to participate in them. She felt that she could again be exposed to contact and wished to avoid this. She referred to 'safe sex' as a possible strategy and implied a reconsideration of whether (hetero)sex was going to play any part in her future.

Whilst there was uncertainty in the *meaning* of the abnormality, in this case Teresa attributed certainty to its genesis. Whilst Teresa could not identify the particular sexual partner or context through whom the virus was introduced into her body, since she recognised that it was possible for this virus to lie dormant for many years, she could, nevertheless, attach her personal sense of risk to a particular sexual relationship. Thus, risk here is embodied in a particular sexual relationship.

Other women drew attention to sexual relationships, sexual health and the risk of developing cervical disease. This was either in explicit reference to viral transmission and HPV or in more implicit references to their own sense of sexual agency. As I have outlined in Section Two, public health and biomedical discourses link cervical disease with sexual activity in epidemiological terms. However, within the process of identifying and managing cervical abnormalities, this link may be subjugated or deployed differentially. Younger, often working class, women may be addressed in terms which mobilise this link whilst older women, often middle class, may be presented with rationales of disease which deny such a link. Within this process of differentiation, young women are positioned as active sexual agents whilst older women are positioned as passive sexual agents.

Younger women in the study were most likely to refer to sexually transmitted diseases in general and HPV in particular in their attempts to

explain the 'causes' of abnormal smears. Chris, for instance, linked her knowledge of screening to sexually transmitted diseases, and suggested that women ought to begin participating in screening when they became sexually active. For Chris, the risk of developing cervical disease seemed to be part of a continuum of risk which she felt her 'generation' experienced. A dominant theme in her account of her own experience of screening participation was that of HIV and AIDS. She linked her experience of negotiating sex to her experience of screening and 'taking care' applied as much to the possibility of infection from HPV as it appeared to apply to HIV. Yet her own knowledge of this link was undermined in her experience of colposcopy and the approach of the clinic staff there.

For instance, she described how she had been asked several questions when she first went to the colposcopy clinic about her sexual activity and contraception. When she indicated that she and her (then recent) sexual partner used condoms, the doctor responded by suggesting she go 'on the Pill'.⁴ Chris was surprised at this since she had thought in the current sexual climate she was being a good citizen and acting responsibly by using condoms. At the clinic:

'They suggested that I went on the Pill which I thought was probably a bit of a strange suggestion...with all that's going on they should be encouraging people to use condoms, not encouraging people to go on the Pill. I suppose the Pill is going to lessen the risk of you getting pregnant but it's not going to lessen the risk of you getting an infection. So, I thought it was a bit strange.' [Chris TU 462-466]

Chris described herself as a young woman who was negotiating her sexuality by 'being careful', by which she meant condom use by herself and her partner. She saw this strategy as a means of not only protecting herself from HIV, but also, as a precaution against the potential for cervical disease. Her understanding of risk incorporated not only HIV but a continuum of infection through which cervical abnormalities might be

⁴ Hawkes (1995) makes reference to the way in which general practitioners, in family planning contexts, may guide young women towards the contraceptive Pill rather than other forms of contraception. 'Responsibility' is interpreted here as the prevention of pregnancy rather than the prevention of disease and poses contradictions for young women.

explained. Sexual activity was perceived as indirectly implicated in the risk of cervical disease by other women.

Similarly, as a consequence of her experience of screening, despite the absence of explicit connections by either the staff at colposcopy or her own general practitioner, Susan perceived sexual activity in terms of a new form of risk.

'I think I'd be really wary, I don't know, maybe it's just how I'm feeling. I'd be terrified in case I got an infection or something like that. Like that would cause abnormalities again or something. I wouldn't have sex without a sheath nowadays anyway - you can't trust anyone.' [Susan TU 94-95]

Susan reflects on her own sexual practice and her perception of the way in which sexual activity has become 'risky business'. Her response to this perception of risk is a presentation of self as someone who will manage sexual encounters through practical strategies to reduce possible risk of infection. For Susan, participating in screening is a rational strategy for dealing with the risk of infection.

In contrast, Claire did not explicitly connect cervical abnormalities to sexual behaviour but was forced to confront this connection in her clinic experience. She had understood an abnormal smear as an indicator of 'pre-cancer' and as something which 'had to be sorted out'. At colposcopy, however, in common with many women, she was asked questions about her 'sex life' and the number of sexual partners she had had. She accepted these questions since medicine had 'made a connection between numbers of sexual partners and cervical cancer' and 'they don't smear virgins'. Yet she found it strange to 'count up over years of one's sexual activity and have to produce a number'. This was odd to her because of the ambiguities surrounding sexual activity and her own questions about what medical culture defined as sexual activity. Did they mean heterosexual penetrative sex alone or other forms of sexual practice? This raised questions for Claire along the lines of 'well, did I sleep with him or not?' and in the context of a colposcopic examination she found herself reconsidering her sexual relationship and their link to her sexual health. Further, they highlight a mismatch between the language which women

use to describe sexual relationships and the way in which biomedical discourse expects a calculative representation of sexual activity.

'Promiscuity' and Risk

The possibility of the risk of sexual activity in connection with cervical disease was also presented to Nicola in the context of history-taking prior to colposcopic examination. The kinds of questions she was asked included:

'The usual stuff about where I lived, what I did, age and so on. Also the doctor asked a sexual history and if I had any partners from Africa, Asia or America, drug users or who were gay. They asked me my age at first intercourse, how many partners I'd had, what sort of contraception I used and the age I first started using the Pill. I think they probably thought I was promiscuous, assumed I'd be on the Pill, anyway, probably because GPs seem to dole them out to young girls. I was used to telling them about contraception - just about every doctor seems to ask you - so I thought, here we go again.' [Nicola TU 17-18]

Because of the responses which Nicola gave to the doctor's questions, she thought she would be defined as 'promiscuous', expressing a perception of a hidden moral agenda. In her recollection of her experience she did not comment on her response to such a judgement, except to note that it may have been made and to critically connect this to the contraceptive practices of general practitioners. Women who thought that they may have been defined by health professionals as 'promiscuous' were at pains to present sexual identities which would not be seen as 'promiscuous'. Kathleen, for instance, explicitly placed herself outside sexual risk in her understanding of what screening entailed. She saw cervical disease as potentially linked to sexual activity but her position was:

'I'm not taking any risks so I'll just get on with it.'
[Kathleen TU 26]

When she went to talk to her general practitioner about her abnormal smear she had an 'unhelpful' experience. Kathleen recalled how 'uptight' she was on that occasion and whilst she acknowledged that the doctor was trying to be reassuring, she also remembered seeing the reaction on her doctor's face to the smear result, and she felt she 'picked up' on that. In

particular, Kathleen was upset about the way in which the doctor explained links between sexual activity and cervical disease.

Kathleen Extract 1: TU 2-33

01 What did really upset me was that she started on
02 about being linked to promiscuous sexual behaviour and that...
03 I've never heard of that...it really upset me,
04 because I'm a fairly monogamous creature.
05 I've been married and then I've lived with someone
06 for another 10 years.
07 I really found that I totally unnecessary statement to be making
08 and particularly since my mother,
09 who only had one sexual partner in her entire life,
10 died of cervical cancer.

First, Kathleen is at pains to identify herself as monogamous. Second, she is critical about the meaning of 'promiscuous' and the way it is used to identify risk. She positions herself clearly outside the boundaries of the concept through the notion of monogamy. Third, she is able to place herself further beyond the link between 'promiscuity' and cervical disease which is being presented to her by referring to her mother's experience of cervical disease and its occurrence in the context of perceived sexual monogamy. Kathleen's powerful rejection of a sexual identity which might be read as 'promiscuous' was echoed by other women who acknowledged an epidemiological link between sexual activity and cervical disease but rejected any risk for them.

Therefore, embedded within women's accounts of their screening experiences were expressions of the ways in which risk could be embodied in sexual relationships. Risk, as a consistent feature of sexual experience was alluded to in the following kinds of comments:

you've got to *think* about it
you've just got to be so *careful*
you've just got to be *sensible*

Medical discourse utilises the category of 'promiscuous woman' but this is resisted and redefined by women themselves through their experience of screening. Some women, whilst drawing on contamination beliefs in order to explain the presence of cervical disease, had in common a sense of themselves as agents in the development of disease. Whilst some women articulated a sense of generalised anxiety about sex as a mechanism of

contamination, others perceived themselves to have some control over the conditions in which such contamination could occur.

Thus, for some women, embodiment was governed by rational actions which they could or might take in response to a perception of the risk of developing cervical disease through sexual activity. Other women discriminated between their sexual identities and those of other women in order to mark them off from those which might be defined as 'promiscuous'.⁵ Whilst such women might acknowledge the *role* which sexual activity could play in viral transmission (and not all women in the study identified sexual activity and HPV as means through which cervical disease might develop), in their recollection of their experiences they presented images of themselves as 'non-promiscuous' women.

Generalised perceptions of the risk of disease, were articulated in a number of ways by women who participated in screening and who experienced abnormal smears. Such women articulate complex understandings about what the nature of risk and how they are personally placed within definitions of risk. The stories told in these interviews suggest that understandings of being potentially at risk of disease in the present do not appear to underpin participation, but rather emerge as a *consequence* of participation. Therefore being in a state of risk and being at risk can both be seen as products of the screening experience.

⁵ Crawford (1994) highlights the importance of boundary marking of self from 'other' through categories such as 'clean' and 'polluted' in relation to HIV. A similar process is evident in the reflection of some women upon the relationship between 'sex' and cervical disease.

Surveillance, Trust and Risk

'The risk is defined more by the trajectory of an individual within and between social spaces than by the characteristics of the spaces themselves. Once more, it is a risk directly associated with biography, meant as the path between the different things that one is and becomes; rather than the 'objective' circumstances met through life.'
(Greco, 1993, p360)

Arguments about risk have emerged alongside sociological discussion of surveillance and are premised on contradictory, though not necessarily incommensurate, views of society (Turner, 1995). On the one hand, risk theorists point to processes of deregulation, through for instance, the expansion of the market (Ritzer, 1993) and the entrenchment of uncertainty as key features of late modernity (Beck, 1992). On the other, Foucauldian sociologists argue that late modernity is characterised by regulatory impulses premised on normalisation strategies which expand surveillance, and therefore, control. As a gesture of theoretical accommodation, Turner (1995) points to two possible solutions to this contradiction, and suggests that risk and regulation might be seen as dual processes, operating on both local and global levels. The internalisation of normative patterns of civilisation such as those described by Elias (1978), produces a desire for everyday predictability, which is reproduced *alongside* the growth of global uncertainties, identified within the emergence of AIDS and polluted environments. Alternatively, as macro deregulation and economic instability increase, then new systems of surveillance and governance may provide a sense of personal control at a local level (Turner, 1995, p226).

As I have argued, these observations are made by examining the practices which constitute surveillance, and I think we can add, the practices which identify risk in terms of markers and social groups. Similarly, on the one hand, Giddens (1990) is attached to the notion of abstract systems as characteristic of late modernity and, therefore, the importance of trust in 're-embedding' the 'disembeddedness' of such systems. On the other, Beck (1992) suggests that the absence of trust in, and the experience of alienation from, abstract systems, is expressed through a 'resigned dependency' on those systems (1992, p6). However, the current framework in which arguments about both surveillance and risk are cast,

suffers from a poverty of gender analysis, and neither the arguments proposed by Giddens or Beck engage with processes which are gendered in their practices and outcomes.⁶ The material I have presented in this chapter, in posing risk as a product of surveillance which characterises the nature of participation, challenges the emphasis which Giddens places upon trust relations in the context of abstract systems, such as that represented by cervical screening.

I have discussed both practices of surveillance and risk in Section Two, but I have also, in Section Three, drawn attention to the ways in which women are drawn into particular kinds of action, such as self-surveillance, and how these practices are negotiated through a sense of embodiment. The material I have presented in Chapter Six, suggests that the displacement of confidence in embodiment, produced through cervical screening participation, produces a heightened sense of trust in cervical screening, as an abstract system. Trust therefore emerges through the negotiation of local, or embodied knowledge, in which embodiment must be seen as a medium of transformation. Drawing on Luhmann (1988; 1993), I have argued that this awareness presupposes risk, which can therefore be seen as a product of surveillance. A negotiated sense of risk emerges in two principal ways. First, drawing on Gifford (1986), the sense of vulnerable embodiment pertaining to cervical screening participation, produces risk as a *state of being*. Second, perceptions of smear misinterpretation and administrative errors harvest a sense of *being at risk*.

Women respond differently to this transformed sense of embodiment, for instance, by shopping around for smears from different venues; by entering into political action, through group membership and discussion; and by explicitly placing trust in the knowledge claims which are mobilised in support of cervical screening. Consequently, I argue that the material I have presented in Chapter Six demonstrates the complexity of risk internalisation and the multiple and varied ways in which women actively produce a risk consciousness in the context of screening.

⁶ Turner (1984) alludes to the gendered nature of the governance of bodies but does so by employing a pathological model of the female body. In Turner's concept of patrism, the female body is a foundationalist target for political technologies, in the sense that he presents it as an essentially troubled body estranged from the mind.

Embodiment, and the sense of transformation which is articulated in relation to it, is critical to this process.

Furthermore, risk internalisation is cross-cut and undercut by the production of citizenship consciousness. In contrast to those who might argue that women require expert reassurance in order to counter the anxiety generated by screening participation, this data illustrates how uncertainty and ambiguity is negotiated by women themselves. Women can and do transform surveillance by reclaiming cervical screening as a social entitlement and as a social obligation in which they position themselves as active subjects of participation. Not only, therefore, is risk 'internalised', but a citizenship consciousness is actively produced in the context of participation in cervical screening. Such consciousness provides a mechanism for managing anxieties about knowledge ambiguities; the market culture in which screening quotas exist, and the expert system in which cervical interpretations are made.

CHAPTER SEVEN

BREAKING IN AND OUT AGAIN: METHODOLOGY, KNOWLEDGE AND NEGOTIATION

'The notion of theory as a toolkit means (i) The theory to be constructed is not a system but an instrument, a *logic* of the specificity of power relations and the struggles around them; (ii) That this investigation can only be carried out step by step on the basis of reflection (which will necessarily be historical in some of its aspects) on given situation.'
(Foucault, 1980, p145, cited in Clifford, 1988, p23)

Introduction

The subject of cervical screening has a certain social power. When asked to talk about the topic of my thesis, the immediate response of many people was enthusiastic. Cervical screening was seen as an issue high on current policy agendas and as one with which 'all' women 'ought' to be concerned. Moreover, responses to my topic by peers typically pointed to access and non-participation as key problems. Similarly, when I turned to feminist literature on women's health, whilst there were few direct references to cervical screening, and far more on breast screening, those which existed, also construed screening as an issue of both access and compliance.

As Chapter Four describes, the concerns of the technical and policy literature have been largely directed towards issues of non-participation, population coverage and the incidence of disease. Furthermore, these concerns have assumed a position in which an implicit goal is to increase women's participation in screening. This has been the case even within feminist studies which have sought to 'give voice' to the authenticity of women's experience. Within this kind of research, whilst women are 'taken seriously' in the sense that their views are sought and addressed, the knowledge which women are said to hold is identified, in many cases, as inadequate. As I described in Chapter Four, prevention discourse produces appropriate knowledge for the purpose of securing compliance, itself defined in women's interests. When women respond to research questions in ways which fail to 'fit' what is defined as 'formal' or objective knowledge, they are perceived as lacking information and requiring expert advice.

Implicit emphasis on the importance of compliance within the project of screening and the identification of embodied or local knowledge as 'deficient' knowledge holds two implications for the way in which I have approached this thesis. Broadly, these are concerned, first, with the process and methodological framework of the research. It is my contention that the normative position adopted by social science approaches to screening is reinforced by a methodological framework which draws on a Health Belief model of action, and research methods which largely rely on surveys to generate descriptive and prescriptive data which can be translated and deployed in relation to policy and information production. The normative position adopted by social science approaches to screening therefore obscures issues of intersubjectivity, interpretation and embodiment.

The second concern is the status of knowledge. The dismissal of some forms of women's knowledge as 'deficient' or inadequate, raises the issue of what counts as knowledge in the first place (see Harding, 1991, for extended discussion of epistemology) and the problematic way in which 'experience' is used in feminist approaches to cervical screening. On the one hand, women's 'experience' is drawn upon as a basis of authenticity with which to challenge medical assumptions about why and how women participate in screening. On the other hand, 'experience', articulated through 'deficient' knowledge, is categorised as inauthentic, in the sense that it fails to generate the right kind of participation, that is, compliance. The methodological framework of the literature which I have described in Section Two, therefore, places emphasis on the authority of the researcher, albeit at times in ways which seek to 'give voice' to those who are researched. Paradoxically, the authority of women as subjects of research is undermined as their accounts are read as indicative of the possession or absence of a particular kind of knowledge.

In seeking to gain access to women's interpretations of the experience of cervical screening in general and of an abnormal smear in particular, I wished to design my own research in ways which would avoid these problems. I wished to adopt a methodological approach which would give voice to the subjects of research yet not reclaim the experiences which these voices revealed, as unmediated authenticity. In common with many

feminist researchers (Scott, 1985 provides extended discussion), I saw in-depth interviews as a method which would enable women to speak and to set their own agenda in the interview context. In the course of analysis, it became much clearer to me that this method reproduces the notion of authenticity which I had perceived as problematic. Analysis of interview data as 'experience' merely reproduced the categories which I deemed problematic in other kinds of research and obscured my interaction with both the discourse of the interview subjects and the production of data as text.

My resolution of this problem was to make interpretation the focus of analysis and acknowledge the 'data' as 'constructed negotiation' (Clifford, 1988). This has allowed me to generate a 'bottom-up' analysis, not in terms of grounded theory, which itself can obscure the process of research (Scott, 1985), but in a Foucauldian sense of local knowledges which emerge from particular discursive contexts and are constituted as texts. This strategy also allowed me to address my own 'situatedness' as a postgraduate researcher; as a trained nurse and as a young woman in ways which enabled me to reflect on the diversity of 'experiences' in women's accounts of cervical screening participation.

Finally, the process of doing and reflecting upon the research has consistently forced me to address the question of what purpose my research might serve. Clearly, it serves both instrumental and value-oriented goals, first in terms of professional accreditation and second in terms of personal enlightenment. The research has another purpose, which is to address the sociological project and the analytic categories embedded within that project. Therefore this chapter reflects upon the process of engaging with that project and the work which goes into the production of sociological knowledge, through a discussion, first, of my negotiation of access to a regional colposcopy clinic; second, of the negotiated character of data collection; and third, of the process of data analysis.

Breaking In: Access Negotiation¹

Negotiating Physical Access

Negotiating access into research settings is an important part of the research process. Research settings vary considerably in the extent to which they are 'open' or 'closed' to public scrutiny and these differences in turn impact on the nature and degree of negotiation necessary to secure access. Part of my research focused on the experience of women in cervical screening participation in general and the interpretation of abnormal smears in particular. I identified a regional colposcopy unit (henceforth the 'clinic'), from which I thought I would be able to construct a sample of women all of whom would have had at least one abnormal smear. This approach also enabled me to identify women who had spent different amounts of time within the cervical screening 'programme'. I anticipated a number of gatekeepers to social and physical access, including medical and nursing staff; Health Board ethics committee members; clerical staff and women themselves, as potential recruits. Unanticipated gatekeepers included men with whom some women shared living space,² and the bureaucratic contingencies of the Health Board ethics committee. Negotiating this latter gatekeeper, in particular, prolonged the period of access negotiation and raised issues of compromise and closure.

Whilst feminist methodological strategies are contested issues about which there is unresolved debate (see Holmwood, 1995 for a recent overview), in identifying potential recruits to my research, I wished to minimise any obligation to participate in the study which women themselves might feel. Oakley (1981) notes the sense of duty which women experience when they are approached to participate in research, particularly in clinic settings, and I did not wish to reproduce those relations of compliance, outlined in Chapter Four, of which I was critical. Furthermore, I wished it to be clear that once women agreed to participate in the study, they could opt out of participation at any point in the process. My concern was to build the potential for agency and resistance into the research design, and to see

¹ Some of the insights in this section were developed in collaboration with Catrin Smith, a fellow postgraduate researcher. In talking about and thinking through our experiences of postgraduate research we identified similarities and contrasts, some of which I discuss here.

² I outline this phenomenon briefly in Appendix I.

women as 'volitional subjects' (Stanley, 1990). Discussions of methodological strategies which claim to be distinctly feminist, argue for an acknowledgement of women's agency (Stanley and Wise, 1993) in implementing research design. Clearly, the right of individuals *not* to be the subjects of research is also discussed in non-feminist literature (see Burgess, 1985). My intention here is not to argue that feminist methodological approaches which claim to be distinct have intellectual continuities with other methodological approaches, but rather, to highlight how I attempted to develop a feminist approach to the design of the research and how this attempt was subject to negotiation.

I therefore adopted a loose, exploratory approach which drew on an interpretive tradition of sociological research. In selecting appropriate methods of research I wanted to ensure that women, as potential participants, were given the fullest possible information about the research and the opportunity to refuse or withdraw from participation at any point. I planned to identify women from clinic records, then write to them asking permission to interview them about their experience of screening. This meant that I would approach women in the clinic myself, rather than ask clerical staff to approach women, in part, in order to establish that I was not part of the clinic culture. They would already know that they had an abnormal smear, so I would not have access to more information about their smear status than they did. My premise was to assume women's agency. However, medical practitioners and committee members also exercised their agency. Therefore, whilst I was able to be self-conscious about my personal negotiation of what I perceived as a hierarchical relation of power, my own sense and exercise of agency, cannot be understood as separate from the process of interaction and negotiation which I entered into.

In order to initiate clinic access I first established an informal link with a consultant who was sympathetic to the research. He suggested I meet with his colleague, who had responsibility for the administration of the clinic. I provided this consultant with a written rationale which outlined the open-ended and exploratory design of the research. I presented the study in general rather than in specific terms and briefly outlined how I planned to identify a sample of women and my methods of data collection,

without explicitly linking the work to sociological concerns. Although this could be described as a progressive entry strategy (Lee, 1993), it was also a way of managing my own anxieties. Although I wished to avoid the misrepresentation of myself in order to gather data, and did not see my representation of my research as a judicious use of truth, I nevertheless had anxieties about representing the open-ended and exploratory nature of the research. This reflected concerns about the do-ability of the research; the perceived imbalance of power between myself as a female researcher and the official gatekeeper to this research setting; my own ambivalences towards the clinic and the project of cervical screening. Despite, or perhaps because of my generalised presentation of the research, the medical manager responded positively.

My previous occupation, prior to entering higher education, was that of a Registered General Nurse in the National Health Service. I was wary of acknowledging this identity in my letter of introduction to the consultant of the clinic for two reasons. First, I did not wish to signal the research as nursing research, and thus identify myself on an epistemological plane not shared by the women whom I wished to interview (see Stanley, 1990). Related to this, I did not wish to re-enter the hierarchical relations between doctor and nurse, from which I had become disengaged. Second, although I was unsure of my identity as a postgraduate researcher, I wished to at least signal my credentials as a sociologist, albeit in training. However, I was placed as a nurse by medical and nursing staff and, therefore, forced to acknowledge my identity as one-time nurse.

This categorisation probably facilitated my access to the clinic. For instance, although the consultant sometimes introduced me as someone 'doing a Ph.D.', he always introduced me as a nurse. Although I impressed upon this consultant that the interviews with women were only a part of the thesis, and that I was not using survey methods, it nevertheless became clear that he saw the research as another 'attitude survey' which he welcomed as a way of revealing local concerns. His first questions, for instance, were: how will this research be representative, and how will it be statistically useful? Therefore, he defined the research according to his terms and made suggestions about my methodological approach. This is an acknowledged aspect of access negotiation (Schatzman and Strauss,

1973) but also illustrates more generally the context of policy creation and evaluation to which all academic research is increasingly being attached.

In particular, the consultant objected to my suggestion that I contact women prior to their arrival at the clinic on the grounds that any letter sent to women prior to their attendance might 'warn' them off (from what he did not say, although this illustrates the normative emphasis placed on compliance). He alternatively suggested that I identify women upon their arrival at the clinic. In his view, once a woman entered the physical space of the clinic she implicitly signalled her consent to medical scrutiny, on the grounds that since the hospital in which the clinic was based was a teaching hospital, people had to expect to be 'guinea pigs'.³ Further, he suggested I approach general practitioners and request 'permission to use their patients', which effectively became a kind of conditional access (Lee, 1993). For the consultant there seemed to be an issue of professional courtesy, and he was clearly anxious to minimise treading on colleagues' toes. Yet this gesture effectively incorporated another layer of gatekeeping, this time outside the hospital, through general practitioners, in ways which invite comparisons with the relationship between gynaecology and general practice outlined in Chapter Three. Here, medical power is seen as incorporative and responsive, in the way that it redefined my research within the terms of medical discourse and introduced a further layer of surveillance.

My response to this implicit *quid pro quo* was twofold. First, I perceived this suggestion as a measure of his professional power to define the nature of the research and potentially operate closure on the project altogether. Therefore I did not feel that I could reject his suggestion to approach women on their arrival at the clinic, because I might jeopardise the research. More importantly, gaining physical access to the clinic created the unintended consequence of having to negotiate another *social* access point, distinct from the women themselves. My initial resistance to what I perceived as medical power, and my attempt to undercut this by incorporating agency for women into the research design, was itself

³ There are parallels to be drawn here between the consultant's representation of the hospital as a space in which people might expect to be the focus of research, and the earlier historical practice of using women as research objects, as outlined in Chapter Three.

transformed into compliance through the process of access negotiation. Consequently, I felt my epistemological and theoretical position was somewhat compromised by accepting the consultant's definition of my research. Yet it is also illustrative both of a more general process of constructive negotiation and reproduces the social relations I have offered for scrutiny in Section Two.

My encounters with nursing and clerical staff in the clinic followed similar lines. After my initial meeting with this consultant, he suggested I make my application to the ethics committee, but in the meantime spend time in the clinic in order to acquaint myself with the procedures and work carried out there. This gave me an opportunity to make links with the ~~the~~ nursing, clerical and other medical staff on an informal basis. My presence was welcomed by many of the nurses, including the sister-in-charge. The nurses I spoke to voiced enthusiasm for the research, and generally adopted a compliance model in which women who neither participated in cervical screening nor attended the clinic at the appointed time, were seen as 'defaulters'. For instance, women were seen as using 'devious tactics' and making 'excuses' to avoid either having a smear, colposcopy or treatment. 'Excuses' included 'having a period' or, the question 'if there is any chance you are pregnant', was seen to be used by women to avoid screening.

As a consequence of the nurse identity imposed upon, but not entirely resisted by me, I was given the freedom of the clinic. In some cases women had come for repeat smears following colposcopy six months earlier and I observed six consultations between women and nurses, with the permission of both participants. Other women had come for their first or repeat colposcopy. I was also invited by medical practitioners to observe two colposcopic procedures. The women who experienced these procedures were asked if they minded the presence of a 'research nurse' and agreed to my presence. Although I had concerns about the way in which I was drawn into observation, it was difficult to refuse this invitation, because of the way in which I was introduced and addressed as a nurse.

Negotiating Social Access: the Health Board Ethics Committee and unanticipated gatekeepers

Assured of the support of the medical and nursing staff, I approached the Health Board ethics committee for permission to use this particular clinic as a base from which to recruit research subjects. This proved to be a time-consuming and painfully bureaucratic procedure. I made clear that this was not a piece of medical research, neither were there drugs trials nor invasive procedures involved. Nevertheless I complied with the application procedures which entailed a lengthy submission of a *pro forma* clearly designed for clinical trials. I attempted to rework my proposal to interview a sample of women drawn from this clinic, with their permission, into a shape which would not sit too awkwardly with the design of the application. This was no easy task.

I intimated that I would approach women in the clinic; that prior to this I would write to their general practitioners in order to ascertain if there was any reason why they should not be approached (I will return to the particular issues this raised for the research); that the interviews would be semi-structured, tape-recorded and take place in a venue of the woman's choice. I also supplied a redrafted consent form (Appendix IV), since the one provided by the committee was inappropriate for the kind of research I wished to undertake, and a 'subject' information sheet (Appendix V), which outlined information about the research for the prospective participants in an informal, approachable way.

In response, I received a request for information about the questionnaire I intended to adopt; a complaint that the nursing hierarchy had no knowledge of the research; and comment on the inadequacy of the consent form I had supplied. I had made clear in the initial application that the method of data collection would entail semi-structured, open-ended interviews and that questionnaires would not be used. In response to the Committee's concern regarding a questionnaire, however, I supplied the committee with a theme guide (Appendix VI), with which they subsequently appeared satisfied.

The final objection was in relation to the consent form I had submitted. This objection was based on the fact that it was not 'the standard type' and

I was sent, forthwith, another form. This form, I noted, was different from the consent form I was sent with the original application, since it now also included the following sentence:

'Your General Practitioner will be informed of your participation in this study and will be advised of any clinically relevant information that comes to light.'

I objected to this on the basis that as a sociologist, I had no business informing general practitioners about clinically relevant information, since I was not in a position to define what was clinically relevant. Hence whilst it is clearly the case that in many situations researchers have found it necessary to comply with certain conditions in order to gain social and physical access, this kind of condition has implications not only for the identity of the researcher involved, but also control over the nature of research itself. A further reason for my objection was the way in which the inclusion of such a phrase would require me to identify the research as something which could be recognised by the medical and nursing profession as fitting into an acceptable biomedical/clinical research paradigm. I consequently resubmitted the consent form which I had originally drafted and requested that the committee consider my position as a sociologist rather than as a clinician. Again I included the 'subject information' sheet which I had drafted as a letter in order to present information more informally and outline the topic of my research for potential participants. This was accepted and I was given permission to proceed.

Closures and Compromises: Negotiating Social Access

As I have indicated, one condition of securing social access, which I felt I had generated, was to involve general practitioners. I identified thirty-nine women as a 'sample' from clinic records in terms of age, category of appointment and consultant, over a period of six months, and approached their general practitioners by a letter, in which I briefly explained the study aims, the location of the study and the name of the woman drawn from clinic records (see Appendix VII). I added the following sentence:

'If there is any *clinical* reason why your patient should not be approached and asked to participate in this study, I would

be grateful if you could get in touch with me...within the next seven days.' [Emphasis not included in original]

Thirty-three general practitioners did not respond. Five acknowledged my letter and expressed discretionary judgements. One general practitioner requested that I did not approach her patient on clinical grounds, in this case, of postnatal depression. Of the other four, two general practitioners asked me not to approach the women concerned on the grounds that they did not consider this to be in the 'interests' of the patient. Another general practitioner, whom I had approached about two women, said she was 'agreeable' to one patient being approached, and had 'no objection' to the other being approached. The final general practitioner of this five wrote to say:

'Thank you for your letter asking permission to speak to Mrs. — at the colposcopy clinic. Frankly I don't think she is going to be all that useful to you as she does tend to get very uptight. However, obviously whether you wish to interview her is up to you entirely.'

I had not asked for 'permission' to approach women, as the excerpt from her letter suggests. I saw my letter as alerting general practitioners to the fact that I was going to approach these women and this placed the onus on them to identify *clinical* reasons why I should not. Only one of these reasons could be recognised as clinical. Three general practitioners identified themselves as gatekeepers of women's general interests and one perceived my letter as a request for information about the *usefulness* of her patient for my study.

These extracts illustrate how methodological closures drafted in a new, unanticipated level of gatekeeping. Not only did the consultant defer to general practitioners on the grounds of professional curtesy, but some general practitioners clearly saw themselves as the guardians of women's interests. I interpreted this as a form of protectionism which undercuts women's right to speak for themselves and in their own voices. My relationship to women as potential research subjects was mediated by general practitioners, based on their assumption that they were the agents in the best position to make decisions about whether women were capable or not of participating in a piece of research. Such

circumscription seemed to replicate precisely those conditions which I had sought to minimise in my early research design.

Because I focused on a clinic culture, which bridges institutional and community social space, the research process revealed that the gatekeepers to social and physical access were not always clear. Furthermore, whilst it was possible to anticipate a number of key gatekeepers, they responded in unanticipated ways, which produced closure and compromise. Hence the process of identifying a sample of women with whom to conduct a piece of research was constructively negotiated. Lee (1993) has argued that when researchers stress the problematic nature of field research the picture which is often portrayed becomes an 'heroic tale', in which the researcher's diligence or artifice overcomes the reluctance of research subjects to participate.

This account is by no means an 'heroic' tale. Rather, it illustrates the way in which my negotiation of researcher-researched relationships reflected issues of power and resistance with which the substance of my research was concerned. In particular, I experienced tensions in my self-conscious adoption of 'feminist methodology', especially where women are positioned as a relatively powerless group in researcher-researched relationships (Finch, 1984; Oakley, 1981). My attempts to overcome this perceived imbalance and ensure the potential for agency in the research process created a shift from my own resistance to compliance, and is more generally illustrative of the substance of the research. Therefore attachment to and renegotiation of feminist ideas about the process and practice of research may be to compromise one's research agenda and reshape the research itself. This highlights a central tension between the research, in terms of the sociological questions it addresses, the theoretical framework in which it is located, and the *doing* of the research, with regard to the methodological and epistemological questions which I have had to address in the process.

Narrative accounts

'In fact the sociologist and his "object" form a couple where each one is to be interpreted through the other, and where the *relationship* must itself be deciphered as a historical moment.' (Jean-Paul Sartre *Critique de la Raison Dialectique* quoted in Clifford, 1988, p55)

Twenty-three women agreed to be interviewed individually.⁴ Interviews, which lasted for, on average, one hour, usually took place within the woman's own home, but eight were carried out in the Department of Sociology at the University of Edinburgh. The interviews were semi-structured and tape-recorded and my questions were broad and general, to encourage respondents to generate their own stories (Bell, 1988) about their experiences of screening. I was interested in what these stories were about, how and why they became meaningful to the women concerned. My approach was to view the accounts which women gave in the interview context as stories or cultural tales, as a form of discourse, which they created around those experiences (Williams, 1984; Mishler, 1986; Denzin, 1988; Thomson and Scott, 1990; Riessman, 1993).

The interview data which the study generated must therefore be seen in terms of my interaction with women's interpretations, as they illuminated my theoretical interests, rather than the unproblematic representation of women's accounts. In approaching the data in this way, I perceived women's accounts as local knowledges which are embodied in a particular way of telling and are located within a particular social context. I have not responded to the data in ways which 'give voice' to women's experience. Rather, I have responded to the data by both expanding and reducing it in ways which allow a chorus of voices to emerge, or a series of 'multivocal exchanges' between myself and the subject (Clifford, 1988), between the subject's discourse and the text, which I have produced.⁵

⁴ Appendix I contains details of the women approached to participate in the study and biographical details of those who continued to participate. See Appendix VI for details of the interview theme guide.

⁵ Clifford (1988) provides extensive discussion of this analytic process in his critique of ethnographic authority, and refers specifically to Ricoeur's work on discourse. However similar points are made within sociological discussions of interpretive frameworks, especially those aligned to narrative analysis (see for instance, Denzin, 1988; Riessman, 1993).

This approach stands in contrast to current social science approaches to cervical screening which place these experiences within Health Belief models of explanation. As Chapter Four described, in this approach, experience is examined to shed light on attitude and belief, with the purpose of identifying problems in the acquisition of knowledge. Knowledge 'gaps' are identified and methods of filling these gaps are developed. A prior conception of the nature of the problem, usually non-compliance, is implicit in this work. In contrast, and in criticism of the model of action implicit in this work, my research began from a more open-ended and exploratory premise which asked women to reflect on and give shape to their experience of cervical screening. My approach treated women's knowledge as linked to and embedded within their experience, and I have examined the ways in which this knowledge was articulated. In doing so, I have sought to identify embodiment in the narratives told by women. Two sociological approaches aligned to narrative analysis have been helpful in this respect.

First is the observation that people make sense of and contextualise their experience through narration. Graham (1983) and Mishler (1986, p69) argue that people tell stories in interviews even where the form of the interview is heavily structured by questions and answers. Bell (1988) emphasises the way in which the stories which people tell in the context of interviews can be used to make links between social structure, social interaction and consciousness. This approach stems from a concern with the interactional aspects of the interview context and the ways in which particular accounts or representations of events are actively constructed in these contexts. In the process of telling, the phenomenon under discussion becomes real. It is therefore situated within a particular historical moment but is also taken beyond this moment through the process of analysis (Denzin, 1988).

For instance, Mishler (1986) poses a distinction between different contexts for the telling of such stories, for instance, the medical world and the lifeworld. His analysis focuses on how the world of medicine impinges upon and transforms the lifeworld and vice versa. When people try to make sense of their experiences outside doctor-patient and clinical contexts, they experience struggle between the voices of their own

particular lifeworlds and that of the medical framework (Mishler, 1986). Further, interviews and the narratives embedded within them can be understood as dialogues or struggles between these two voices. Consequently, in order to deal with the question of how people make sense of their experiences, in Mishler's approach, analysis focuses on issues such as which voice dominates; on which explanations do women draw to articulate their experiences and how are their understandings transformed?

Whilst this approach is valuable, it has a tendency to separate each 'world' from the other in representing particular narratives and to separate the lifeworlds of the teller and the listener in the co-construction of an account (Denzin, 1988). Within a Foucauldian framework, the boundaries between these two worlds are less clear, since they are constituted in discourse. Hence the task for analysis should be to give an account of the process through which discourse, as a mode of communication in which the presence of the speaking subject and of the immediate situation of communication are intrinsic, becomes text (Clifford, 1988, p39). The discourse of the teller is present and non-transcendent, in contrast to the data generated and transcribed into textual form, which is open-ended.

Therefore, drawing on Clifford's discussion of Ricoeur (Clifford, 1988), for discourse to become text it has to come 'autonomous' or separated from its specific utterance and authorial intention and so experiences become narratives or meaningful occurrences. In this way, analysis becomes a constructive negotiation which involves subjects who move between discourse and text, or which takes text, in the form of theoretical propositions, to the data for support, refines them and develops them in the light of what is conceptualised in the data (Ramazanoglu, 1992). Here analysis moves back and forwards between transcripts or text and theory (Holland, Ramazanoglu, Scott, Sharpe and Thomson, 1994). This approach allows for diverse narratives within a single account and retains the contradictions and inconsistencies within discourse, or places marginal discourses and subjugated knowledges (Haraway, 1991) as a *focus* for analysis, rather than as a problem for analysis. These concepts highlight knowledges which develop in the context of interacting with the world of,

for example, medicine, but are interpretively transformed into local, embodied knowledges.

There are a variety of ways in which narrative analysis can be undertaken. One is to focus on the organisational framework of the narrative itself (its form) and how it is structurally organised. This approach is taken by Riessman (1993) who explores narrative organisation around time and episode. This approach preserves the form of talk and emphasises the work which the production of such talk entails. Another is to explore narrative content and development. This is the approach taken by Bell (1988) in her study of 'diethylstilbestrol (DES) daughters'. Bell emphasises how women's understandings of their experiences as DES daughters lead to their politicisation and she examines the medical uncertainties faced by these women; their response and the consequences for their identity. She interviewed women by asking open-ended questions to allow them to introduce their own issues, then analysed narratives within single cases. In one interview for instance, there might be three stories, which she then argued could be linked by exploring similarities within and across stories. This approach, by focusing on content (what the stories are about) and form (how they became meaningful; or how the stories were produced in the interview), allowed her to demonstrate change over time, because of the ways in which stories emerged, tying events and significant social relationships together. This approach links social structure and social interaction with identity formation through the concept of a core narrative and the process of how meaning is accomplished.

A further approach to narrative analysis is that of Williams (1984) who develops the concepts of narrative reconstruction and genesis in order to reveal the explanations people give for chronic illness. In contrast to accounts which place emphasis on 'causal' factors identified in health beliefs (for instance, Pill and Stott, 1982), Williams tries to demonstrate the ways in which illness talk reveals narrative reference points between the individual and society. People present narrative reconstructions of their changing relationship to the world in which they live, or local effects, and the genesis of illness within it.

Williams argues for two instances of narrative: the 'routine' and the 'reconstructed'. The former refers to 'the observations, comments, and asides, the practical consciousness which provides essential accompaniment to the happenings of our daily lives and helps to render them intelligible'. Here narrative is a process of 'continuous accounting' in which the everyday events of daily life are placed in some kind of order, although not necessarily teleological. His use of biography, develops a concept of narrative which refers to the reciprocal connections between individuals, their private 'settings of milieux' and wider public issues (Mills, 1959).

Williams demonstrates, in one case study of a man with rheumatoid arthritis, who links its onset and development to workplace toxicity, that for this man, 'the body is defined by its relationship to the world of social action not in isolation from it' (p182). Furthermore, this understanding of the body is distinct from a medical model of ascertainable facts and objective observations. For Williams, the body is both an object in the world but also the medium 'through which our consciousness reaches out towards and acts upon the world' (p197). Williams draws on Marx's view that consciousness is derived from materiality, and further suggests that consciousness is 'biographically framed'. This approach develops a dialectical approach to the relationship between body, rather than embodiment, and society. Whilst consciousness may be mediated through the body, the ways in which consciousness of the body is interpreted and expressed will 'lead us to call upon images of the private and public lives we lead' (p197). Therefore narrative reconstruction is an attempt to *repair* ruptures between body, self and society.

In addition to this concept of reconstruction, Williams uses the concept of genesis to refer to reference points within a narrative which may be constituent parts of the imaginative reconstruction of the 'past so that it has meaning or purpose for the present'. I have been cautious of his use of genesis because of the way in which it explicitly refers to a sense of teleology. Feminist epistemologies, in particular, point to the non-linear and unteleological way in which people experience and recount their experiences (Riessman, 1993). Time may well be implied in narrative reconstructions, but not necessarily in linear form. Indeed, the issue of

temporal ordering is problematic in narrative analysis.⁶ Nevertheless, Williams demonstrates how episodes within narrative reconstructions constitute reference points which are mobilised to bring order and meaning to illness events and experiences.

Conclusion

I have adapted these approaches to examine women's accounts of their experiences of cervical screening; their sense of embodiment and the meaning imputed to these experiences. I have not used the data to draw attention to lay beliefs or folk theories about the causes of specific diseases, nor have I used the data to point up distinctions between medical and lay understandings of disease. Approaches which identify 'knowledge gaps' have been used in ways which deny the authenticity of lay knowledge. I have not treated women's experiences as lay knowledge which needs to be corrected, but as knowledge which has to be understood within the context in which it is produced and through the meanings which are given to it by women themselves. I have therefore used the interview data to examine how the cervix is produced as a site of knowledge across biographical time.

In contrast to the subjects of Williams' study, the women I interviewed talked about experiences of prevention rather than chronic illness. A feature of this experience is the way in which women are asked to consider, and indeed accommodate, the possibility of future disease. For many women this possibility poses a disruption to embodiment in ways which require reinterpretation and accommodation. The 'larger interpretive process' in which women come to understand and articulate their experiences can be considered a 'narrative reconstruction'. There are parallels between Williams' approach and Mishler's distinction between the world of medicine and that of the lifeworld. With reference to the way in which one of his interviewees places his experience of rheumatoid arthritis, in the context of exploitative social relations in the workplace, Williams says:

'When issues of diagnosis are removed from the quiet location of the doctor's clinic and situated within the context of a struggle for compensation, the neutrality of the medical

⁶ Riessman is drawing upon Ricoeur's work on time and narrative here.

task and the objective validity of its procedures are thrown into doubtful relief.' (1984, p185)

This implies that people transform the medical world they encounter through the particularities of embodiment, and the discourse by which such encounters are bound, by relocating and incorporating experiences in the lifeworld in ways which produce local knowledges. Analysis therefore focuses on the form of telling, on the assumption that there is correspondence between form and the experience of reality. For instance, in the retelling of an experience which acknowledges the reality of medical culture, individuals may highlight an ontologically different reality by inserting a 'narrative enclave' (Young, 1989). This breaks the narrative frame and highlights a shift from general to local knowledge.

Williams' work finds some commonality with feminist and interactionist analysis of the situated work which people do in their representation of experience (see most recently Atkinson, 1996). This work focuses on how stories are told and begins analysis from the inside out, rather than by looking for content and confirmation of presuppositions. This highlights epistemological issues in relation to the production of sociological knowledge through relational encounters, in which the production of such knowledge is the outcome of particular sets of interactional negotiations.

Historical truth and authenticity is important for current approaches to the experience of cervical screening. I have taken a distinct approach to this issue which attends to the way in which local knowledges emerge in the process of reflection. I have not used the interview data to support theoretical claims but rather to illustrate and develop theoretical arguments and to highlight the coherence and disruptions between local knowledges in the world of medicine and local knowledges which emerge in particular contexts of embodiment. Locating the body more centrally in both substantive and theoretical concerns opens up the issue of embodied knowledges and subjectivities for exploration in order to demonstrate how immateriality - ideas, texts, constructs - is materialised and internalised, in ways which become a lived experience (see Smith, 1991, for instance). I have used this insight to examine how ideas, texts

and practices are lived out and inform action and experience. This allows me to explore the ways in which medical culture may address the body as an abstraction and examine how this notion of the body is taken up, internalised and materialised into a particular body in the context of prevention.

Hence, the 'body project' of this thesis, has been to generate empirical data which it brings into dialogue with feminism, Foucault and sociology, in order to articulate a status for the body in sociology and feminism. The methodological approach of the thesis picks up issues in relation to the status of embodiment within sociological and feminist work on the body. By placing emphasis on embodiment, it becomes possible to establish a sociological project which engages with the interaction of 'the' body, embodied experience, and the nature of social participation and membership in late modernity.

EPILOGUE

In this thesis I have presented material which I have used to 'think through the body', that is, to both follow through the issues presented for sociology by the body and to examine how the body is deployed as a medium of local, individual, transformation. I initiated my discussion of the body at the level of general theory and traced current sociological perspectives on the body. Consideration of the limitations of general theory has led sociology to other approaches, the most distinctive and dominant of which are Foucault and feminism. However, I have argued that whilst these approaches are critical to the development of sociological address to the body, each contains unresolved tensions.

Within Foucauldian sociology, engagement with the body under surveillance places too much significance upon processes of regulatory power such that resistances, forms of disciplinary power and self-surveillance are effectively obscured. It is my contention that the arguments generated within this framework have focused too readily upon *practices* of surveillance, which conceal *experiences* of surveillance and self-surveillance. A significant implication of this is that the body persists as an object of scrutiny in ways which bracket out particular, or situated, knowledges and experience. In contrast, I have argued that second wave feminism should be seen as a statement of the particular, but one which has generated its own, unresolved, tensions. On the one hand, significant discussion within feminism has been concerned with embodied experience, as a source of authenticity. On the other, embodiment has been addressed in abstract and philosophical terms. Nonetheless, despite these tensions, I have argued in support of the potential for these approaches for considering embodiment as a process of interaction, or dialectic, between the body as object or idea and embodied experience.

One of the key areas for debate about the body has been in relation to regulation and surveillance. Prevention has emerged as a notable substantive area in which these discussions have taken place and I therefore offered cervical screening, as an instance of surveillance, for review. I examined discourses and local practices which have contributed

to the creation of the cervix as an object of scrutiny within medicine and social science. The emergence and development of cervical screening is characterised by a range of enduringly contested knowledges across these various sites. I have argued, consequently, that within both medical practice and the evaluations of social science, compliance emerged and remains a crucial concern. The contested or ambiguous knowledge which governs medical practice is dependent upon generating the means of securing compliance, and, I have argued, the most distinctive of these include obligation and risk.

Cervical screening offers a concrete example of an abstract system and therefore raises questions about the nature of interaction and experience within such a system. I have used the notion of embodiment to examine and highlight two notable aspects of this experience. First, the strength of obligation to participate in screening is apparent in the accounts of women I have presented here. Whilst neo-liberal notions of obligation arise in these accounts in ways which support arguments about the emergence of lifestyle and liberal governance as characteristic of health in late modernity, this is by no means the only way in which notions of obligation are expressed. I have identified authoritarian notions of social duty, entitlement and a sense of care in these accounts and I have suggested that these point to a sense of citizenship as a product of the experience of screening. Second, I have argued that risk should be seen as a product of the form of surveillance exemplified by cervical screening. Women's interpreted accounts of their experience point to both risk as a state of being and being in a state of risk. These articulations of risk express connections between the abstract system of which screening forms part and local experiences which are derived from, and transformed through, embodiment.

Two principal implications arise from this thesis for understandings of the relationship between the body, gender and health. First, the discursive transformation from diagnostic testing to prevention embedded within the emergence of cervical screening has implications for the current framework in which screening operates. The interpretive debates associated with medical practice in the middle of this century are enduring debates which cut across the social organisation of screening,

laboratory practice and the experience of screening. Whilst the material I have presented here reveals the persistence of contested knowledges, further research is clearly required to specify the precise nature of the links between and across different social sites, and their consequences for the experience and negotiation of prevention. Second, whilst the expansion of surveillance continues to be a critical theme within Foucauldian sociology, particularly that associated with issues of health and prevention, the material I have presented here suggests that focus on the body obscures those local experiences with which both feminism and Foucault have ostensibly been concerned. In contrast, the notion of embodiment, or 'thinking through the body', as a mode of local transformation, reveals previously obscured aspects of surveillance, such as obligation and risk. Therefore, surveillance must be examined *in relation* to citizenship, not as distinct from it, in order that the paradoxes embedded within prevention can more clearly be seen.

APPENDIX 1

Details of Women Who Participated in the Study

All names presented in this thesis have been changed to protect anonymity. Thirty-nine women, who had participated in screening over varying periods of time, in the predominantly urban social context of south-east Scotland, were identified through regional colposcopy clinic records. The colposcopy clinic provided me with a small room in a corridor between the reception and the waiting area. When those women, identified as potential recruits, arrived at the colposcopy clinic, I approached them to ask if they would be willing to talk with me briefly prior to their appointment. I outlined the rationale of the study and asked if they would be willing to participate. Five of the thirty-nine women I initially identified did not attend the clinic on the appointed day. Thirty-four women initially agreed to be interviewed by me at a venue of their choice, at which point I collected demographic details such as age, occupation, civil status, and parity. We chatted briefly and then I arranged to telephone them at home in order to arrange a time and place for interview.

Of these thirty-four women, two women later declined to participate, one woman (46 years) on the grounds that as she worked and lived outwith the city in which the study was conducted, it 'was not handy for her'. Another woman (60 years) declined on the grounds that her husband was about to retire and they planned to travel to France and stay there indefinitely. In addition, eight women who had initially agreed to participate in the research, withdrew. Of these eight, one young woman (21 years) telephoned me to tell me that she did not wish to take part in the study as she was upset by, and did not wish to discuss, the treatment she had experienced in the clinic. Another three women (30 years, 42 years, 55 years) were neither at home when I telephoned nor responded to written cards.

The remaining four women who withdrew did so indirectly through men with whom they shared living space. Of these four women one (38 years) withdrew the day following her appointment 'after discussing it with [my] husband'. Another woman (21 years), agreed to be interviewed in my

office but did not arrive. When I telephoned her to try and arrange an alternative appointment, a male voice ascertained my identity before telling me that this woman was 'unavailable'. I also experienced this response when I tried to telephone another young woman (21 years). When I called the final woman (31 years) the telephone was answered by a man who first asked me what I wanted to talk to her about and then told the woman in question that 'that woman' (me) was on the telephone. This woman withdrew on the grounds that she didn't think she would be 'any use' to me.

A feature of interest in these responses is the way in which many of them are managed initially by men. There are a number of potential explanations for this. First, women may have deployed an 'intermediary' to convey the 'bad news' of their withdrawal from the study. Second, it could express a 'client resistance' to the perceived authority associated with those with institutional affiliation, and therefore illustrative of the 'agency' which I was trying to incorporate into the study. Third, male 'ownership' of women in the context of cervical screening has been identified, where men are seen to be diffident about their partner's participation in cervical screening (McKie, 1996). For some men, the smear taking event is defined in sexual terms as an experience which either their partner or the smear-taker might 'enjoy' or as an event in which details of male sexual activity might be implicitly disclosed.

None of the women who continued to participate in the study had been initially pro-active in their screening participation but had been asked to have a smear in the context of one of the following:

1. Family Planning
2. Pregnancy and Childbirth
3. General Practice
4. Other

Four women who had their first ever smear in a Family Planning Clinic did so within the ten years prior to the study. Three of these women were in their late teens at the time of their first ever smear and perceived the smear test as part of the 'routine' experience of moving into 'family planning'. Some women indicated that they knew little about the purpose

of a smear test but felt obliged to participate. Seven women had their first ever smear in the context of pregnancy and childbirth: three women had their first ever smear at a booking clinic, one only three years prior to our interview, one thirteen years prior to the interview and one twenty-one years prior to the interview. Four of these seven women had their first ever smear at a post-natal clinic across the previous twenty one years prior to our interview.

Twelve women had their first ever smear within general practice: three at registration; five as opportunistic smears in the contexts of visits to their doctors for other reasons; and four as part of 'Well Woman' examinations. This latter category all received their first ever smear within the last six months prior to the interviews, just after the introduction of *Promoting Better Health* (DHSS, 1987) and *General Practice in the National Health Service: the 1990 Contract* (DoH, 1989). Of those five women who experienced opportunistic screening, four received their first smear within the last seven years and one had done so thirty-three years prior to our interview. Amongst the women receiving their first ever smear upon health centre registration, only one did so more than seven years prior to the interview. One woman had her first smear in the context of a gynaecological examination abroad at the age of twenty-four and another young woman had her first ever smear in the context of a termination of pregnancy about which she talked at length in her interview. Her articulation of her screening experience was deeply embedded in her accounts of her experience of abortion and I have not presented any of her transcript here as data.

Biographical Details of Interview Participants				
NAME	AGE AT INTERVIEW	CIVIL STATUS	CHILDREN	SMEAR STATUS
Ann	28	married	none	new Patient
Mary	40	divorced	2	detail not recorded
Julie	32	single	none	new patient
Sheila	34	single	1	recolposcopy
Chris	21	single (boyfriend)	none	recolposcopy
Teresa	40	single	none	new patient
Eve	44	married	4	recolposcopy
Claire	44	divorced	1	recolposcopy
Linda	37	single (boyfriend)	none	recolposcopy
Fiona	30s	married	2	6 monthly screening
Ivy	33	married	2	recolposcopy
Lorna	40	married	2	recolposcopy
Susan	36	divorced	1	new patient
Margaret	59	widowed	3	new patient
Liz	30s	married	2	annual screening (self initiated)
Rose	39	married	2	recolposcopy
Diane	27	single	none	new patient
Jane	62	widowed	3 or 4	recolposcopy
Kathleen	47	divorced	none	recolposcopy
Carol	28	married	daughter of 7 months	new patient
Pat	40s	separated	4	3 yearly screening
Alice	30s	cohabiting	none	annual screening
Nicola	27	cohabiting	none	3 yearly screening

APPENDIX II

Cytological Classification System

Laboratory smear reports on cervical cell changes are not standardised and vary in the level and nature of reporting. The following is adapted from a text designed to explain cytology reports simply and to help establish 'good cytology practice' (Hopwood, no date). In some centres the range of reports may be limited to *negative*, *suspicious* or *positive*. Other laboratories report a range of changes which represent a continuous spectrum of cell abnormalities. These include:

negative
inflammatory
severe inflammatory
mild dyskariosis
moderate dyskariosis
severe dyskariosis
invasive cancer

The term *dyskariosis* refers to nuclear abnormalities. The exact stage at which a benign change becomes a potentially cancerous one cannot be ascertained with certainty. *Cervical Intraepithelial Neoplasia (C.I.N.)* is histological terminology which indicates that the cell changes are restricted to the epithelium, but the following terms are sometimes used on the cytology report:

C.I.N. 1	mild dysplasia
C.I.N. 2	moderate dysplasia
C.I.N. 3	severe dysplasia

Practices vary, but women receive information about their smear status either by letter or phone. They may be told their smear is negative and they will be recalled for a further smear in three years' time. If their smear shows abnormal changes they will be asked to contact their general practitioner who will arrange for a repeat smear or colposcopy, depend on the degree of abnormality.

APPENDIX III
Clinic Characteristics 1987-1992

Total Number of New Patients 1987 - 1992 = 10,503

Total Number of Return Visits = 21,391

AGE @ REFERENCE	MARITAL STATUS	TREATMENT
<16 = 3 (0.01%)	Single (3488)	None (1190)
16-20 = 248 (7.6%)	Married (5483)	Laser (1885)
21-25 = 755 (23%)	Separated (535)	Cold Coagulation (4572)
26-30 = 750 (23%)	Divorced (1064)	Laser/Cold Coagulation (40)
31-35 = 552 (17%)	Widowed (128)	Loop Diathermy (2919)
36-40 = 361 (11%)	Stable Relationship (51)	Lasercone (5)
41-45 = 265 (8%)		Other (169)
46-50 = 168 (5%)		
51-55 = 77 (2%)		
56-60 = 58 (2%)		
61-65 = 18 (0.5%)		
66-70 = 12 (0.4%)		
>71 = 3 (0.03%)		

APPENDIX IV
Consent Form

Further information is available from:

Alexandra Howson
Department of Sociology
University of Edinburgh
18 Buccleuch Place
Edinburgh
EH8 9LN
Telephone: 650 3991

I agree to participate in this study.

I have read this Consent Form and the Information letter and had the opportunity to ask about them.

I understand that I am under no obligation to take part in this study and a decision to not participate will not alter the treatment I would normally receive.

I understand that I have the right to withdraw from this study at any stage.

I understand that this is non-therapeutic research from which I cannot expect to derive any benefit.

Signature of Subject_____

Name of Subject_____

Signature of Investigator_____

Date_____

APPENDIX V
Subject Information Letter

Research on Women's Views of Cervical Screening

Dear Patient

I would be grateful for your help. This study aims to explore women's experiences of the prevention and treatment for cervical cancer, and is interested in your views and experiences of cervical screening. This information will be used as part of a Ph.D. thesis based in the Department of Sociology at the University of Edinburgh, and is looking at the experiences of women involved in cervical screening, and its history.

Your name has been drawn randomly from a list of women attending this clinic. If you agree to take part in this study, I would like permission to interview you twice: (a) briefly, before you see the doctor or nurse, in order to gather some basic information (occupation, address, age) and arrange a convenient time and place to visit you after your appointment; (b) after this appointment, in order to conduct a fuller interview concerning your experience of preventive treatment. If you agree, I would also like to come with you when you are interviewed by the doctor or nurse.

Everything you say will be strictly confidential, and used only in conjunction with this study. You are, of course, under no obligation to participate, and should you agree to do so, you may withdraw at any time. If you have any questions about this study, I can be contacted at the above address.

Thank you for your time.

Yours sincerely

Alexandra Howson

APPENDIX VI
Interview Theme Guide

Could you tell me about your prior contact with doctors and the health service?

Could you tell me about the first time you had a cervical smear?

What did you think the purpose of the smear test was?

Had you thought about your cervix much before that?

Could you tell me why you are currently at the clinic?

What did you expect might happen at the clinic?

Were you given any explanations about your current experience?

How has this affected your life in general?

What would you say your views are now about screening?

How has this affected other people in your life, your partner, for instance?

How would you say you think about your body?

What impact has this experience made on your thoughts about the future?

APPENDIX VII
General Practitioner Letter

Research on Women's Views of Cervical Screening

Re: Patient Name and Date of Birth

Dear

I would be grateful for your help.

This study aims to explore women's experiences of the prevention and treatment for cervical cancer through in-depth interviews. This information will be used as part of a Ph.D. thesis based in the Department of Sociology at the University of Edinburgh. With the permission of Lothain Health Board the project is based in the Regional Colposcopy Clinic at the Royal Infirmary of Edinburgh and has received approval from the Paediatrics/Reproductive Medicine Ethics of Medical Research Sub-Committee.

Your patient's name has been drawn randomly from a list of women attending the Regional Colposcopy Clinic. If she agrees to take part in this study, I would like to interview her at her convenience about her views and experiences of cervical screening.

If there is any clinical reason why your patient should not be approached and asked to participate in this study, I would be grateful if you could get in touch with me at the above address within the next seven days.

Yours sincerely

Alexandra Howson

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